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BARRIERS AND ENHANCERS TO PARENT-ADOLESCENT DISCUSSION ON SEXUAL REPRODUCTIVE HEALTH ISSUES AND HIV PREVENTION METHODS IN MOUNT DARWIN

BY

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Abstract

Adolescents are those people between 10 and 19 years. There are 1.2 billion adolescents in the world, making up 16% of the world's population. Parent-adolescent discussion influences adolescents' knowledge, attitudes and behavior. The more parents discuss issues such as sexual intercourse, the lesser the probability that the adolescents will be engaged in risky sexual behaviors. Today, parents find it difficult to discuss sexual reproductive health issues with their adolescents. This increases the chances of having unplanned pregnancies, early marriages and infections of sexually transmitted diseases particularly HIV/AIDS among adolescents. Mount Darwin district has the highest teenage pregnancies prevalence in the country standing at 37%. Mount Darwin district recorded a total of 1716 cases of teenage pregnancies, 833 of them among girls between the 16 and 17-year age group during the lockdown period stretching from March 2020 to February 2021. The aim of this study was to identify barriers and enhancers to parent-adolescent discussion on sexual reproductive health issues and HIV prevention methods in Mount Darwin. Both cross sectional quantitative and phenomenology qualitative study designs were used where 220 participants (120 adolescents and 100 parents) from Mount Darwin and Chironga high schools were recruited into the study. Schools were purposively sampled whilst stratified random sampling was used to sample adolescents. Parents/guardians for the selected adolescents were then automatically recruited into the study. Questionnaires and interview guides were used to collect data during interviews and focus group discussions (FGDs) respectively. Quantitative data was analyzed using SPSS version 22 through descriptive statistics and bivariate statistics and was presented using tables and percentages. Qualitative data was analyzed thematically and presented using narrative notes. The study revealed that 48.5% of the adolescents were exposed to the discussions by the parents (p-value = 0.384). Girls had significantly higher odds of engaging into sexual reproductive health (SRH) related discussions than boys (Odds Ratio [OR] = 1.2; 95% CI: 0.7 – 2.1; p= 0.046). Adolescents aged 15-17-years had significantly higher odds of engaging into SRH discussions with their parents (OR = 2.4; 95% CI: 0.5 – 11.8; p = 0.029). Female parents had significantly higher odds of engaging into discussions on SRH issues with their children compared to male parents (OR = 1.3; 95% CI: 0.7 – 2.1; p = 0,038). Parents aged 45-49 years had significantly higher odds of discussing SRH related issues with their children (OR = 4.9; 95% CI: 1.0 – 25.0; p = 0.05). During FGDs the themes that came up included cultural construct, low parental knowledge as main problems and perceived benefits as an enhancer to discussions. The study concludes that parent adolescent discussion on SRH related issues is not a common practice in Mount Darwin and culture, religion parental low knowledge and parental responsibility denial are some of the barriers to discussions whilst perceived benefits and fear for stigma are enhancers to discussions. The study recommends that the hospital outreach programs and community health workers must do community based awareness campaigns targeting parent's knowledge and attitudes providing much needed information to boost their knowledge and clearing cultural misconceptions on parent-adolescent discussion on SRH related issues.

Keywords: Parent; Adolescent; Discussions; Sexual reproduction

Declaration Page

I declare that this dissertation is my original work except where sources have been cited and acknowledged. The work has never been submitted, nor will it ever be submitted to another university for the award of a degree.

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Copyright

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Dedication

I dedicate this work to my dear family, my wife Elizabeth and son Tadiwanashe, who gave me the reason to soldier on when I had reasons to give up. I also dedicated this work to the Almighty God for His extraordinary grace that pulled me through when it seemed impossible.

List of Acronyms and Abbreviations

AIDS	-	Acquired Immunodeficiency Syndrome
ASRH	-	Adolescent Sexual and Reproductive Health
GOZ	-	Government of Zimbabwe
HIV	-	Human Immunodeficiency Virus
MOHCC	-	Ministry of Health and Child Care
SRH	-	Sexual and Reproductive Health
UNAIDS	-	Joint United Nations Programme on HIV/AIDS
UNDP	-	United Nations Development Programme
UNFPA	-	United Nations Population Fund
UNICEF	-	United Nations Children's Fund
WHO	-	World Health Organization

Definition of Key Terms

Adolescents: people between 10 and 19 years of age (WHO, 2018).

Behavior: the way in which one acts or conducts oneself, especially towards others (UNFPA, 2016).

Discussion: conversation or debate concerning a particular topic (Yibrehu & Mbwele, 2020).

Health: a state of complete physical, mental and social well-being and not merely the absence of infirmity (WHO, 2018).

Parent: one of the two persons from whom one is immediately biologically descended, a mother or a father (Yibrehu & Mbwele, 2020).

Prevention: specific population based and individual based interventions aiming to minimize the burden of diseases and associated risk factors (WHO, 2018).

Reproduction: the act of reproducing new individuals biologically (UNDP, 2016).

Sexuality: is the way people experience and express themselves sexually, this involves biological, erotic and physical feelings and behaviors (Mekie et al., 2020).

Table of Contents

Abstract …… iii
Declaration Page …… iv
Copyright …… v
Acknowledgements …… vi
Dedication …… vii
List of Acronyms and Abbreviations…… viii
Definition of Key Terms …… ix
List of tables…… xiii
List of figures …… xiv
List of appendices…… xv
CHAPTER 1 INTRODUCTION
1.1 Introduction…… 1
1.2 Background to the study…… 2
1.3 Statement of the problem …… 4
1.4 Purpose of the study…… 5
1.5 Specific objectives…… 6
1.6 Research questions…… 6
1.7 Justification of the study…… 6
1.8 Significance of the study…… 7
1.9 Summary…… 8
CHAPTER 2 LITERATURE REVIEW
2.1 Introduction…… 9
2.2 Conceptual framework…… 9
2.3 Relevance of the conceptual framework to the study…… 11
2.4 Factors affecting adolescent engagement into risky sexual activities…… 12
2.4.1 Exposure to pornographic materials…… 12
2.4.2 Parental monitoring…… 12
2.4.3 Smoking cigarettes and drug abuse…… 12
2.4.4 Religion…… 13
2.4.5 Influence of culture…… 13
2.4.6 Peer pressure…… 13
2.4.7 Biological changes…… 14
2.5 Attributes of sexual and reproductive health discussions…… 14
2.5.1 Content of sexual and reproductive health discussions…… 14
2.5.2 Timing of sexual and reproductive health discussions…… 16
2.5.3 Frequency of sexual and reproductive health discussions…… 17
2.5.4 Comfort level during sexual and reproductive health discussions…. 18

2.6 Sources of sexual health information……..….18
2.7 Parent-adolescent discussion and sexual and reproductive behavior……....20
2.8 Barriers to parent-adolescent discussion on SRH issues ……..…….....21
2.8.1 Gender differences…….….21
2.8.2 Education level of parents…….....….21
2.8.3 Traditional norms…….…….…….…….…22
2.8.4 Religion……...……23
2.8.5 Availability of parents …….……...……...23
2.9 Enhancers of parent-adolescent discussion on SRH issues……..…….23
2.9.1 Perceived benefits and importance…….…….24
2.9.2 Fear for stigma…….……...…….24
2.9.3 Parents education……. ….…….24
2.9.4 Bigger and well established families……...……25
2.10 Summary…….…….25
CHAPTER 3 METHODOLOGY
3.1 Introduction…….……...27
3.2 Study design…….…….…….…27
3.3 Study site…….…….…….…….27
3.4 Study population…….…….…….29
3.4.1 Inclusion criteria ……29
3.4.2 Exclusion criteria …….…….....29
3.5 Sample size…….…….…….….29
3.6 Sampling procedure…….…….…….30
3.7 Data collection instruments…….…….….31
3.8 Pretesting of instruments……...32
3.9 Data collection procedure…….…….32
3.10 Analysis and organization of data…….…….….34
3.11 Ethical considerations…….34
3.12 Summary…….36
CHAPTER 4 DATA PRESENTATION, ANALYSIS AND INTERPRETATION
4.1 Introduction …….…….37
4.2 Demographic characteristics ……37
4.3 Exposure to sexual and reproductive health discussions …….39
4.4 Frequency of discussions …….41
4.5 Frequently discussed topics …….42
4.6 Location of sexual and reproductive health discussions …….……43
4.7 Methods of discussions ……45
4.8 Barriers and enhancers to parent-adolescents' discussions …….…….46
4.8.1 Findings from adolescents …….……47
4.8.1.1 Theme 1: Parent-adolescent discussion on SRH is important but missed. .47
4.8.1.2 Theme 2: Few parent-adolescent discussion practices …….…….….48

4.8.1.3 Theme 3: Puberty time to initiate discussions ……....49
4.8.1.4 Theme 4: Cultural construct as the main problem ……49
4.8.1.5 Theme 5: Gender and age influences on discussions ……...50
4.8.1.6 Theme 6: Parents deny their responsibility ……....51
4.8.1.7 Theme 7: Parents' fear ……51
4.8.1.8 Theme 8: Adolescents have better knowledge than their parents ……51
4.8.1.9 Theme 9: Religion is a barrier ……...52
4.8.1.10 Theme 10: Parents are busy ……. ……...52
4.9 Findings from parents …….…….…….....53
4.9.1 Theme 1: Parent-adolescent discussion on SRH issues is important but missed ….53
4.9.2 Theme 2: Few parent-adolescent discussion practices ……...……. ….53
4.9.3 Theme 3: Puberty time to initiate discussion ……54
4.9.4 Theme 4: Culture as the problem …….….54
4.9.5 Theme 5: Parents are busy ……54
4.9.6 Theme 6: Parents deny responsibility ……...55
4.9.7 Theme 7: Adolescence have better knowledge …….55
4.9.8 Theme 8: Fear from parents of early sexual engagement …….56
4.9.9 Theme 9: Gender and age influence on discussion ……. ….56
4.9.10 Theme 10: Religion as a barrier …….…….……56
4.10 Enhancers of discussions ……...57
4.10.1 Findings from adolescents …….….57
4.10.1.1 Theme 1: Perceived benefits ……57
4.10.1.2 Theme 2: Fear for stigma …….57
4.10.2 Findings from parents …….58
4.10.2.1 Theme 1: Perceived benefits ……58
4.10.2.2 Theme 2: Fear for stigma …….58
4.11 Summary ……59
CHAPTER 5 SUMMARY, CONCLUSIONS AND RECOMMENDATIONS
5.1 Introduction ……60
5.2 Discussion ……...60
5.3 Conclusions ……65
5.4 Implications ……66
5.5 Recommendations ……...67
5.6 Suggestions for further research …….……68
5.7 Dissemination of findings ……68
5.8 Delimitations ……69

5.9 Limitations of the study ……...69
References…….…….……...…70

List of tables

Table 1: Demographic characteristics …….…….37
Table 2: Mean and median age for participants ……...38
Table 3: Exposure of participants to parent-adolescent discussion on SRH issues ….40
Table 4: Frequency of discussions ……...41
Table 5: Location of SRH discussions …….44
Table 6: Methods of discussions …….…….45

List of figures

Figure 1: Conceptual framework of parent-adolescent discussion on SRH…….10

Figure 2: Mount Darwin district map……..……..…….28

Figure 3: Frequently discussed topics …….42

Figure 4: Methods of discussion …….46

List of appendices

Appendix 1: Informed consent ……74

Appendix 2: Assent form for 15 – 17 year-old ……77

Appendix 3: Interview guide for focus group discussion ……80

Appendix 4: Questionnaire for adolescents' interview ……82

Appendix 5: Questionnaire for parents' interview ……85

Appendix 6: Permission to conduct study from PED…….....88

CHAPTER 1 INTRODUCTION

1.1 Introduction

Adolescence is a phase of life of people aged between 10 and 19 years, which is very important for laying the foundation of good health (World Health Organization [WHO], 2018). This stage marks a continuum of physical, behavioral, cognitive and psychosocial changes which are characterized by increased levels of individual autonomy and a growing sense of identity and self-esteem. There are 1.2 billion adolescents in the world, making up 16% of the world's population. The greatest proportion of adolescents is found in Sub-Saharan African where adolescents contribute 23% of its total population. In Zimbabwe the adolescent population constitute 22% of the total Zimbabwean population (United Nations Children's Fund [UNICEF], 2018). Adolescents are the fastest growing group of population especially in the low income countries.

Adolescence in Africa have presented with early marriages and early pregnancies. Unintended early pregnancy is ranging from 18 to 29% among all pregnancies in all African countries (Wado, Sully & Mumah, 2019). The adolescents are disproportionately affected by the human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS), mainly those in Sub Saharan Africa. It is estimated that 80% of HIV infections are among adolescents with girls being four times at risk than boys (Joint United Nations Programme on HIV/AIDS [UNAIDS], 2019). This has led to a significant number of adolescents dying each year due to avoidable sexual and reproductive health problems such as unsafe abortion and sexually transmitted infections. The deaths can also be attributed to low access to and/or uptake to sexual reproductive health services (WHO, 2018).

The survival, health and wellbeing of these adolescents is important as it promotes development, ends poverty and promotes resilience especially among developing countries. Adolescents are the most powerful agents for improving their own health and building prosperous and sustainable societies (WHO, 2016). The purpose of this study was to identify barriers and enhancers to parent-adolescent discussion on sexual reproductive health issues and HIV prevention methods in Mount Darwin. A mixed method research approach was used where both cross sectional design was used for quantitative approach and phenomenology design for qualitative approach were employed in the study.

1.2 Background to the study

Adolescence is an age category where individuals begin to develop identity and self-image. At this stage they begin to explore concept of education, career and marriage and examine how their roles fit into their future. This stage is also important because it is the time they lay the foundation of good health in adulthood (Nigussie, Demissie & Abedaw, 2020). There is physical growth during adolescence which is accompanied by rapid growth and maturation of their sexual organs and because of these changes they become more interested in their sexuality. The changes are usually overwhelming and this calls for need of information, support and experimentation from these adolescents. It is at this stage that discussion about reproductive health issues and HIV prevention methods are important between parents and adolescents (Mekie, Addisu, Melkie & Taklual, 2020).

Parent adolescent communication influences adolescents' knowledge, attitudes and behavior since parents are often willing and an accessible source of information for their children. The more the parents discuss issues such as sexual intercourse, pregnancies and sexually transmitted infections including HIV with their adolescents, the lesser the probability that the adolescents will be engaged in risky sexual behavior and the greater the probability that they will delay their debut sexual act (Nigussie et al., 2020).

Several studies have shown the benefits of parent-adolescent discussion on sexual reproductive health issues. Teens who benefited from parental guidance and those who reported had a good talk with parents in the last year about sex, dangers of sexually transmitted diseases and birth control methods were two times more likely to use condoms and other forms of contraceptives at the last time they had sex than teens who did not talk to their parents as often (Kamangu, John & Nyakoki, 2017). In another study by Mullis, Kastrinos, Wollney, Taylor and Bylund (2021), adolescents who were feeling connected to their families and parents were more likely to delay engaging in sexual intercourse than the other teens who did not feel connected to their parents.

Today, parents find it difficult to discuss sexual reproductive health issues and HIV prevention methods with their adolescents. They hardly educate their children on this vital information and this has led their children into risky sexual behaviors such as inconsistent condom uses and sexual intercourse with multiple sexual partners. The mentioned behaviors increase the chances of having unplanned pregnancies, early marriages and infection of sexually transmitted diseases particularly HIV/AIDS (Usonwu, Ahmed & Curtis-Tyler, 2021).

Globally, parent-adolescent communication has been noted to be infrequent. In a study done in the United States of America to understand communication between adolescents and their parents, about 300 college students out of 400 participants reported that they never had a discussion with their parents on sexual and reproductive health issues (Muhwezi at al., 2015). This justified the increase in new HIV infections among adolescents. About 80% of new HIV infections globally are among adolescents. Adolescent fertility rate among Latin-American girls is 61 per 1000 girls (United Nations Population Fund [UNFPA], 2020).

Adolescents in Africa remains at high risk for sexually transmitted infections, female genital mutilation and early pregnancies (Usonwu et al., 2021). About 18 – 29% of adolescents in Africa had unintended pregnancies. West and central Africa has the highest adolescent fertility rate in the world which is 108 per 1000 girls followed by east and southern Africa with 95 per 1000 girls (UNFPA, 2020). However, adolescents in Africa mostly view sex related discussion with parents as uncomfortable and interactions are driven by fear of personal, social and economic consequences of sexual risk taking behavior (Usonwu et al., 2021).

Locally, Zimbabwe has seen an increase in child marriages, early pregnancies and new HIV infections among adolescents. About 80% of all new HIV infections are among adolescents and about 25% of female adolescents are married. This is characterized with a prevalence of about 25% of parent-adolescent discussion on sexual reproductive health issues (UNFPA, 2016).

1.3 Statement of the problem

Mount Darwin district has the highest teenage pregnancies prevalence in the country standing at 37%. Adolescent fertility has been on the increase in Mount Darwin district from 99 live birth per 1000 women in 2005 to 115 live birth per 1000 women aged 15-19 years in 2016 (UNFPA, 2016). A quarter (25%) of female adolescent are married or are in a union by the age of 18, while 24% of adolescents had begun child bearing in Mount Darwin district (Government of Zimbabwe [G.O.Z], 2019). About 80% of new HIV infections is among adolescents in the district. Mount Darwin district recorded a total of 1716 cases of teenage pregnancies, 833 of them among girls between the 16 and 17-year age group during the lockdown period stretching from March 2020 to February 2021 (Mavhunga, 2021). These high rates of adolescent pregnancies and child marriages have seen high rate of cesarean sections and high maternal and new born mortality rates in Mount Darwin district. The district recorded 315 adolescent cesarean cases, 34 adolescent maternal deaths and 86 new born deaths during the lockdown period stretching from March 2020 to February 2021 (Mavhunga, 2021). This can be assumed that parents are not comfortable to talk about issues related to sexuality with their children. Where these discussions occur, parents provide scanty information about sexual matters (United Nations Development Programme [UNDP], 2016).

1.4 Purpose of the study/ broad objective

The purpose of this study was to identify barriers and enhancers to parent-adolescent discussion on sexual reproductive health issues and HIV prevention methods in Mount Darwin.

1.5 Specific objectives

This study sought to:

1. To determine the prevalence of parent-adolescent discussions on sexual reproductive health issues and HIV prevention methods in Mount Darwin.

2. To establish factors that hinder reproductive and sexual health discussions between parents and adolescents in Mount Darwin.

3. To identify factors that encourage parent-adolescent discussions on sexual reproductive health issues and HIV prevention methods in Mount Darwin.

1.6 Research questions

The study was responding to the following questions:

1. What is the prevalence of parent-adolescent discussions on sexual reproductive health issues and HIV prevention methods in Mount Darwin?

2. What are the factors that hinder reproductive and sexual health discussions between parents and adolescents in Mount Darwin?

3. What are the factors that encourage parent-adolescent discussions on sexual reproductive health issues and HIV prevention methods in Mount Darwin?

1.7 Justification of the study

The study identified gaps that existed between parents and adolescents that negatively affected their discussion on sexual and reproductive health issues and HIV prevention methods. The study provided evidence based recommendations to fill the gaps that existed on the parent-adolescent discussions. The study also provided community based strategic interventions to improve parent-adolescent discussion on sexual and reproductive health issues and HIV prevention methods.

1.8 Significance of the study

The study will help policy makers and the government of Zimbabwe to come up with policies and laws that protect adolescents from risky sexual activities there by eradicating public health problems caused by early teenage pregnancies and early teenage marriages. The study was also important as it determined the prevalence of parent-adolescent discussion on sexual reproductive health and HIV prevention methods in Mount Darwin. The prevalence was found to be low, and the study informed public health officers to come up with health education programs and campaigns. The campaigns helped to bring behavior change and encourageed parents to have discussions with their children on sexual and reproductive health issues as these were found to reduce risky sexual behaviors among adolescents.

The study aimed at identifying barriers and enhancers to parent-adolescent discussion on the sexual reproductive health issues and HIV prevention methods in Mount Darwin. Upon completion and publication of results, the study was important to health practitioners and other key stakeholders in the area of practice and research. The study gave health practitioners clearer understanding of the roles they can play in promoting

effective application of parent-adolescent discussions in improving adolescent sexual reproductive health and HIV prevention. The results and recommendations generated from this study also contributed to the body of knowledge of health practitioners which in turn improved health and quality of life of the people of Mount Darwin district and Zimbabwe as a whole through improved implementation and access of adolescent sexual reproductive health services.

1.9 Summary

This chapter looked on the introduction of the study, background of the study, problem statement, broad objectives of the study, specific objectives of the study, research questions, justification of the study, significance of the study, delimitations and limitations of the study.

CHAPTER 2 LITERATURE REVIEW

2.1 Introduction

This chapter is going to review previous studies relevant to the barriers and enhancers of parent-adolescent discussion on sexual reproductive health issues and HIV prevention methods. Effort was made to review studies relevant to the research objectives and questions being addressed by this study. A search for empirical literature using electronic databases was done to identify relevant articles and books. Thus was the basis for this literature review.

2.2 Conceptual framework

Discussion about sexual reproductive health issues and HIV prevention methods issues between parents and their adolescent children is a complex process. Whether or not discussion leads to behavioural changes, depends on the aspects of the discussion process (for example the source, the message, the audience and the channel) as well as the elements which influence and determine behaviour (for example attitudes, norms and perceived control).

Studies on parent- adolescent discussion on reproductive and sexual health have used a variety of social and developmental theories to conceptualize the findings including the social learning theory and the theory of planned behaviour. In an attempt to encourage a more standardized approach to research on parent-adolescent sexuality communication,

Jaccard et al. (2002) developed a common theoretical framework which combines the most pertinent elements of each of these theories as shown in figure 1 below

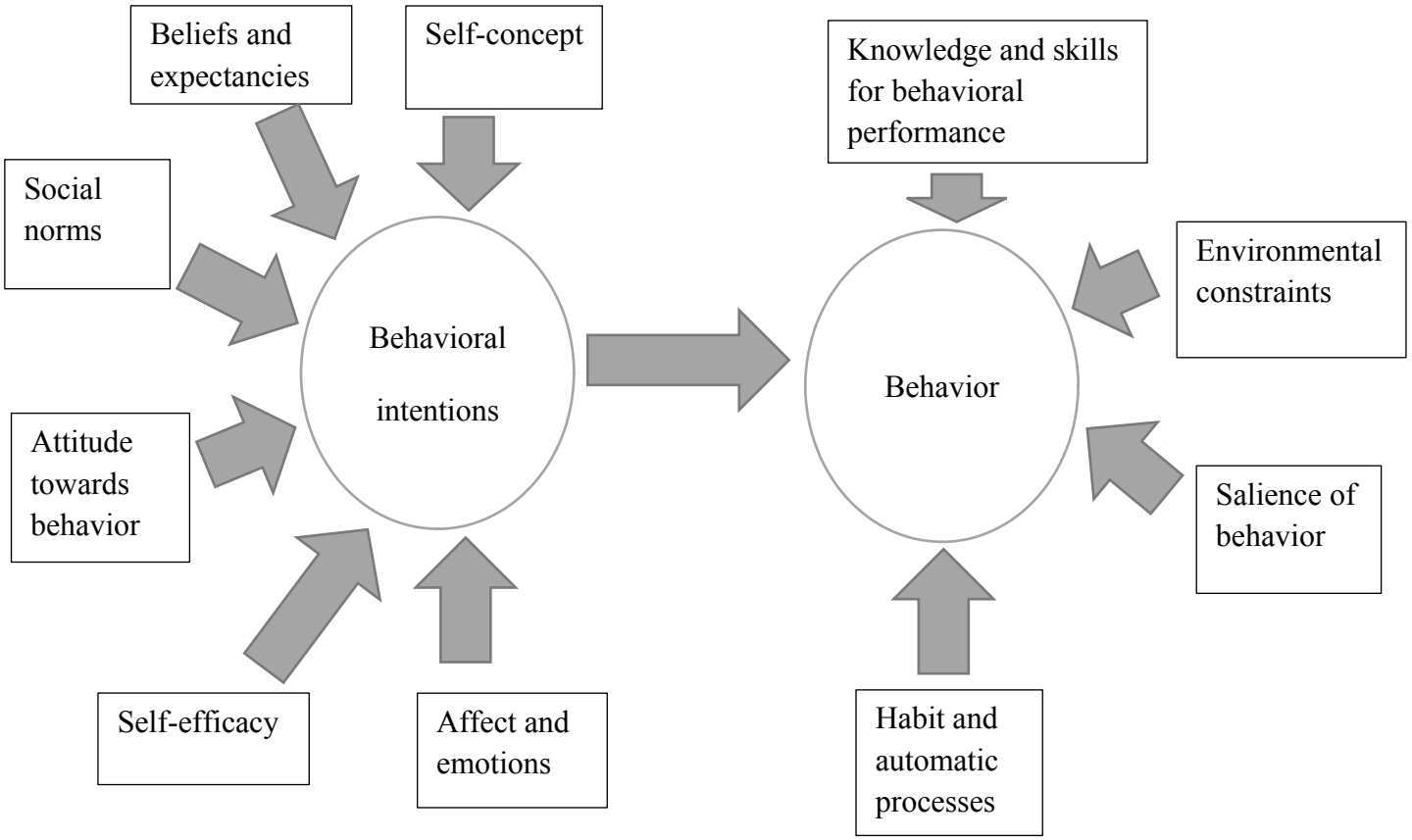

Figure 1: Conceptual framework for parent-adolescent discussion on sexual reproductive health issues and HIV prevention methods – Adapted from Jaccard, Dodge and Dittus (2002)

According to the framework, if parental –adolescent discussion addresses rule setting and restriction of movements (for example curfews) it relates to environmental constraints which influence behaviour directly. However, if discussions focus on challenging peer pressures and social norms around risky sexual behaviours, it influences behaviour intentions which can then influence behaviour.

2.3 Relevance of the conceptual framework to the study

The conceptual framework was relevant to this study because it generated the order in which the study flowed and had set focus and boundaries for the study on parent-adolescent discussion on sexual and reproductive health.

The conceptual framework showed how factors like participants' social norms, beliefs, expectations, affects, emotions, knowledge, skills and environmental constraints affect behavior intentions which was communication between parents and adolescents in this study. The behavior intention has influence on behavior change which in this study was parent-adolescent discussion on SRH related issues. The factors mentioned above, which are shown by the conceptual framework to affect behavior intentions can come out as barriers and enhancers to behavior change. In this study, engagement of participants in parent-adolescent discussion on sexual and reproductive health related issues was the expected behavior change.

2.4 Factors affecting adolescent engagement into risky sexual activities

2.4.1 Exposure to pornographic materials

Exposure can be through media such as watching television, reading magazines and the use of social media like WhatsApp and Facebook. Adolescents who are exposed to pornographic materials are more likely to initiate sexual activity before the age of 18. This could be due to the fact that pornographic materials can stimulate psychological and mental sexual desire and empress to experiment what has been observed. The impulsive nature of pornographic materials leads to erotic sexual stimulation or early sexual practice which usually results in early pregnancies and early marriages (Mahapatra & Saggurti, 2014).

2.4.2 Parental monitoring

Adolescents with good parental monitoring are less likely to start sexual activity earlier than those who had poor parental monitoring. Effective parental monitoring of children's behaviour, attitude and values has a significant role in reducing poor decision making on sexual and reproductive life (Mazengia & Worku, 2009).

2.4.3 Smoking cigarettes and drug abuse

Children who smoke cigarettes and abuse drugs are more likely to start sex at an early stage. This is due to the effect of substance which alters healthy thinking ability of the youth and results in unplanned and unsafe sex (Kassahun, Gelagay & Muche, 2019).

2.4.4 Religion

Religious institutions have been focusing on advising and counselling individuals to delay sexual initiation and discourage sex before marriage, substance use and multiple sexual partners. Generally religious institutions play an important role in youth to develop healthy lifestyle. Usually adolescents who participate in religious education programs are less likely to initiate sex at an early age (Gizaw & Jara, 2014).

2.4.5 Influence of culture

Girls are more likely to initiate sexual activities before the age of 18 years than boys. This is due to the effect of culture that forces females to marry at young age. There are family arranged marriages where the girl child is forced into marriage to a rich family usually in times of hunger in exchange of food staff and other material goods. The adolescent can be forced in an early marriage as a way of appeasing the spirit of the dead or will get married to her aunt's husband after the death of her aunt. Another cultural activity which can cause adolescents to engage into sex early is genital mutilation of the girl child and initiation into adulthood. This can sexually stimulate the adolescents and lead then into wanting to experiment sex. Besides, boys have greater access to education than girls (Mazengia & Worku, 2009).

2.4.6 Peer pressure

During adolescence, the family as context for socialization declines in importance and the peer group increases in importance. Under peer group are the values and attitudes for significant others such as close or best friends as well as their actual behaviours. The adolescents will believe more in their peers and their behaviours will be influenced more

by that of their peers. As a result, if their peers are having risky sexual activities they will be more likely to do the same (Kassahun et al., 2019).

2.4.7 Biological changes

The biological process of maturation involves the development of innate physical capacities, including motor skills, the development of hormonally linked sex motivation or sex drive and physical maturation. Early pubertal development (for example age at menarche for girls, level of pubertal development for boys) is associated with early initiation of sexual activity. This can be explained biologically and socially. Under biological, the increase in hormonal levels at puberty causes increased sexual motivation and sex drive. This increased motivation leads to an increase in sexual activity. Socially, the development of secondary sex characteristics at puberty (for example breast development, hair growth) act as a signal that the individual has matured and is ready for sexual activity. Puberty development leads to sexual activity through its social interpretation I.e., physical attractiveness to the opposite sex (Kassahun et al., 2019).

2.5 Attributes of sexual and reproductive health discussions

The attributes of sexual and reproductive health discussions comprise of content, timing and frequency of interaction between parents and adolescents and their views on how comfortable these parents and adolescents feel during discussion (Usonwu et al., 2021).

2.5.1 Content of sexual and reproductive health discussions

This looks at what and why of ASRH communication and conversations which are often broached in the context of morality, undesired outcomes of sex, social consequences and

religious expectations. Discussions are centred around abstinence from sex until marriage, the negative direct consequences of engaging in premarital sex on adolescents' health and indirect consequences on future social and economic prospects. In a study on parenting practices and styles associated with adolescent sexual health in Dar es salaam Tanzania (Kajula, Darling, Kaaya & De Vries, 2016) adolescents felt the need for information and reassurance from parents about body changes during puberty and relationships. However, adolescents expressed that parents mostly resorted to negative tone including threats, demands, misinformation, warnings and scare tactics about the dangers of sex to emphasize the need for abstinence.

In other studies, adolescents reported more positive, open discussions about sex, communicated in friendly tones with counsel and advice (Muhwezi et al., 2015). In this same study by Muhwezi et al. (2015) parents justified the primacy given in their conversation to health consequences of premarital sex such as HIV/AIDS and other sexually transmitted infections, unplanned pregnancies and implications for adolescents' educational and economic attainment and reputations in the community.

Parents do not talk about sex as a natural experience or one to be enjoyed as this would undermine the case for abstinence. In some instances, parents deliberately misinform adolescents about condoms to create fear and discourage their use (Muhwezi at al., 2015). In study by Butts et al. (2018) on HIV knowledge and risk among Zambian adolescents and younger adolescent girls: challenges and solutions, it was reported that open discussions on use of condoms and contraceptives were driven by the realization that adolescents may get sexual health information from other sources and cannot be

constantly monitored, as well as parent's own experience of sexual exploration during their adolescence.

2.5.2 Timing of sexual and reproductive health discussions

This relates to when and the why the sexual reproductive health communication which includes the prompts, as well as the importance of the timing of discussions. Age of the adolescent can trigger a discussion between a parent and the adolescent on issues of sexuality. Parents can start discussions at the age where they perceive that adolescents can understand conversations and messages. These discussions can also be started at a time when parents realize that their children have had an exposure to sexual health information from sources like mass media and school. These discussions will be necessary at this time because parents will see it necessary to explain or control the information that their children would have received. Another reason for the discussion will be because the adolescents will be seeking clarity from the information they would have received (Usonwu et al., 2021).

Discussions can be started at a time when the adolescents show physiological and pubertal changes. It will be important for parents to start conversations early and timely before adolescents before adolescents begin exploring sexual activities. Onset of puberty or societal interaction can also trigger parent-adolescent discussion on adolescent sexual and reproductive health issues. The triggers can include onset of menarche, voice changes and interest in social activities. The need of adolescents to understand their body changes will push them to engage in a discussion with their parents whilst parents

will be trying to prevent unwanted adolescent pregnancy due to parents' perception of increased risk (Usonwu et al., 2021).

Negative events in the community such as pregnancy of other adolescents, deaths from HIV/AIDS related complications can also trigger discussions on issues of sexuality between parents and adolescents. Parents will be reinforcing messages to protect adolescents from negative consequences of risk taking behaviours and maintaining reputation in the community. Behaviour changes among adolescents such as changes in dressing, partying and watching media with sexual content can also trigger parents to engage into such discussions. This is because parents will be afraid of increased sexual activities and the need to protect adolescents and their families from societal stigma associated with behaviour deemed to be inappropriate (Usonwu et al., 2021).

2.5.3 Frequency of sexual and reproductive health discussions

Communication between parents and their sons is noted to be infrequent. Nolin (2002) reported that only half of the boys in their study had engaged in a conversation with their parents about sex, social issues relating to sex, or contraception. Other studies have reported that the majority of parents had never had a meaningful discussion with their sons about sex, safe sex, sex before marriage or peer pressure (Eisenberg, Sieving, Bearinger, Seain & Resnick, 2006). In a US study that sought to understand boys' communication with their parents reported that, of the almost 300 college students who were asked retrospectively what their parents had told them about sex, nearly a quarter answered 'nothing', meaning discussions never took place (Eisenberg et al., 2006).

2.5.4 Comfort level during sexual and reproductive health discussions

This captures how comfortable adolescents and parents feel about sexual and reproductive health related communication. For adolescents this varies from being very comfortable, satisfied, excited and hopeful, to being uncomfortable and bored. In a study by Krugu, Mevissen, Prinsen, Ruiter and Muleya (2016) on who's that girl? A qualitative analysis of adolescent girls' views on factors associated with teenage pregnancies in Bolgatanga Ghana, adolescents expressed a preference for conversations with their mothers compared to fathers, explained by the closer relationship with mothers. Their relationships with their mothers was described as warm and open. In the same study, adolescents overwhelmingly described sex discussions with fathers as non-existent, rare, difficult and uncomfortable. This was due to distant relationships with their fathers. There was overall feeling of comfort and trust in parents to give useful sexual health advice through discussions on topics they have life experience in such as the onset of menarche.

2.6 Sources of sexual health information

Besides their parents, adolescents have other relevant and preferred sources of sexual and reproductive health information that can impact their sexual health decision making. Multiple studies in urban and rural setting have identified schools as an important source of sexual health information for adolescents (Kajula et al., 2016). In a study by Uswonu et al. (2021), adolescents felt that classrooms were a more relaxing, free and open environment to learn about sexual health issues and expressed a preference for learning from school over mass media channels such as radio and the internet. They further

expressed that they acquired broader knowledge on sexual health issues from school because they had the opportunity to ask questions to help clarify confusion and read books. Overall, adolescents reported positive experiences about sex education received in schools which enabled informed decisions about their sexual health.

Exchange of stories and experiences with peers, and advice for challenging situations are also valued sources of information for adolescents. In a study by Kajula et al. (2016) adolescents expressed that they could talk with their peers at school about positive and negative sexual health topics, particularly relationships, without reservations, fear or judgement. In the same study, adolescents reported that they preferred to confide in their peers to other family members.

Health care centres and healthcare workers are another source of information for adolescents on issues of sexuality. While openness of discussion with peers is valued by adolescents, there is recognition that peers may be unreliable source of sexual health information. Health care centres and health care workers have been identified as sources of accurate sexual health information (Krugu et al., 2016).

Other relatives like grandfathers, uncles, aunts and sisters can also be sources information. Other adolescents prefer discussing with these relatives to their parents with comfort and protection from parental judgement. Culturally, it is the same group of people which conduct traditional initiation ceremonies and provide opportunities for sexual health information and teaching adolescents sexual norms and expectations in preparation of marriage (Uswonu et al., 2021)

Adolescents living in urban areas can get information on sexual health by engaging with sexual health programs and adverts on television or radio and this can also serve as prompts for parents to initiate discussions with them (Muhwezi et al., 2015).

2.7 Parent-adolescent discussion and sexual and reproductive behaviour

The impact of parent-adolescent discussion on issues of sexuality such as sex, contraception, HIV and pregnancy risk, results in delayed sexual initiation, reduced sexual activity and improved use of condoms and/or other contraceptives. It also results in increased communication between adolescents and their sex partners, a lower risk of pregnancy, and increased self-efficacy to negotiate safer sex (Hutchinson, Jemmott, Jemmott, Braverman & Fong, 2003). Serious parent-adolescent discussions about sex and condoms can be especially important for adolescents in communicating with sexual partners about sexual risk and condom use and in preventing adolescents from conforming to more permissive peer norms about sexual risk-taking. Adolescents who talked with their parents about sex were more likely to believe that parents, rather than peers, provide the most useful information about sex (Whitaker & Miller, 2000).

The association between parent-adolescent communication and adolescent sexual and reproductive behaviours may depend on parent values, attitudes, and responsiveness. Adolescents, whose parents clearly express their values and beliefs, including those who communicate strong disapproval of sexual activity or unprotected sex, are more likely to avoid risky sexual behaviours (Hutchinson et al., 2003).

2.8 Barriers to parent-adolescent discussion on sexual and reproductive health issues

There is no good communication existing between parents and adolescents on sexual and reproductive health issues as well as HIV prevention methods in comparison with other issues related to life such as politics, sport and games where parents are free to discuss with their adolescent children (Bushaija, Sunday, Asingizwe, Olayo & Abong'o, 2013). Five barriers can be linked to crippling this discussion between parents and their adolescent children as below.

2.8.1 Gender differences

Discussion between parents and adolescents on sexuality and reproductive health issues exists but it is however limited by gender. Mothers and fathers of the adolescents far more discuss with the child of the same sex. Mothers communicate more often with girls than boys and fathers rarely discuss with boys than girls (Bashaija et al., 2013). This is attributed to the fact that both parents feel shy, hence find it difficult to openly talk to their children. Ina study on barriers to parent-child communication on sexual and reproductive health issues in East Africa: a review of qualitative research in four countries (Kamangu et al., 2017), parents revealed that they find it difficult to discuss with their children because it is a shame for them and even the children. Parents felt that once they engage their children in a discussion of that nature the child will say that the parent want to have an affair with them.

2.8.2 Education level of parents

Parent level of education has an influence to parent-adolescent discussion on sexuality and reproductive health issues. Educated parents have the patience to talk orally and face to face with their adolescent youths as compared to parents with less or without education. Moreover, they can use different mediums to discuss with their children other than oral or face to face. They can use learning materials such as books related to topics, something which is missing to parents with low or without education (Seif & Kohi, 2014).

In a study on caretaker-adolescent communication on sexuality and reproductive health my perceptions matter: a qualitative study on adolescents' perspectives in Unguja-Zanzibar (Seif & Kohi, 2014) it was found that the problem of limited knowledge among parents prevents them from discussing with their adolescents. Sometimes the parents do not know how to discuss such issues because they are not informed. When they want to discuss about pregnancy they do not have enough information about reproductive system.

2.8.3 Traditional norms

This is the other barrier that prohibits parents to discuss issues of puberty and sexuality with their children. The norms prohibit parents and other health professionals to speak about issues of sexuality to adolescents hence shy away and lack courage. Studies by Bushaija et al. (2013) in Rwanda and Svodziwa, Kurete and Ndlovu (2016) in Zimbabwe reiterated that it is an abomination, shame and insult for parents to talk about sexual issues with their children as they teach their children how to act and behave as an adult. It is culturally not acceptable and considered a taboo for parents to discuss these

issues with their children. Culturally, these discussions should be carried out by grandfathers, grandmothers, uncles and aunts.

2.8.4 Religion as a factor affecting parent-adolescent discussion

Religious beliefs usually stand as a stumbling block to discussions between parents and adolescents on issues of sexuality and reproductive health (Svodziwa et al., 2016). The greater number of believers are Christians and these prohibit their followers from committing adultery marriage, practicing abortion and use of contraceptives such as condoms. They encourage abstinence. In a study by Bushaija et al. (2013) parents were quoted saying that as Christians they cannot advice their adolescent children to use condoms which is immoral. Extreme religious practices have prevented parents to discuss with their children on the best ways to reduce sexual and reproductive health risks.

2.8.5 Availability of parents

Parents' occupations account for the other barrier for parents to discuss with their children on issues of sexuality and reproductive health. Self-employed parents have regular returns to their homes, hence they may have time to discuss with their children. This is contrary to those who are publicly employed with tight schedules who have little time to be with their children. They are too busy to have a discussion with their children (Svodziwa et al., 2016).

2.9 Enhancers to parent-adolescent discussion on sexual and reproductive health issues

Enhancers to parent-adolescent discussion on sexual and reproductive health issues exist and these include fear for stigma, perceived benefits and importance, community based campaigns and bigger and well established families.

2.9.1 Perceived benefits and importance

Studies have shown that perceived benefits and importance motivates discussion between parents and their adolescents on issues of sexuality. In a study by Usonwu et al. (2021), adolescents believed that receiving education from their parents can help protect them from harmful sexual health related issues and hence the need for open discussion with parents on issues of sexuality. In the same study, economic benefits from daughter's bride price and the desire to maintain family reputation gave the parents the need to engage into an open discussion with their children on issues of sexuality. They believed this will help to monitor and control their adolescents' social associations.

2.9.2 Fear for stigma

In a study by Usonwu et al. (2021) on parent-adolescent communication on adolescent sexual and reproductive health in Sub-Saharan Africa: a qualitative review and thematic synthesis, parent initiated discussions from a place of fear. Unmarried adolescents, unwanted pregnancies and abortion were sources of stigma and these were seen as sources of shame to parents as parents were often blamed for actions of their children. In this study, parents expressed that they were driven to initiate sexual health discussions

because they were apprehensive of children bringing the family name to disrepute in the community. The importance of guarding reputation acted as a driver for open discussion.

2.9.3 Parents education

Yibrehu and Mbwele (2020) in their study on parent-adolescent communication on sexual and reproductive health in Addis Ababa Ethiopia concluded that community based campaigns by hospital outreach programs and community health workers targeting parent's knowledge enhances communication between parents and adolescents on issues of sexuality. Poor parental knowledge was seen to be one of the barriers to parent-adolescent discussion on sexuality issues and improving this knowledge through community based health education campaigns with enhance discussions between parents and adolescents.

2.9.4 Bigger and well established families

Bigger and well established families are more likely to engage into parent-adolescent discussions on sexual and reproductive health issues. Also good family relationships have a positive effect on these discussions. The bigger the family is in size, the more these discussions are to be carried out. In a study by Shiferaw, Getahun and Asres (2014) on the assessment of adolescents' communication on sexual and reproductive health matters with parents and associated factors in Ethiopia, it was revealed that those adolescents whose family size was less than three were less likely to communicate compared to those whose family size was greater than seven. This was due to the fact that as the number of children increases, parents are more concerned and have communication on sexual and reproductive health issues compared to small family sizes.

2.10 Summary

This chapter gave an in-depth focus on related literature about the study. Previous studies done on parent-adolescent discussion on sexual and reproductive health issues and HIV prevention methods in Africa and the world at large were discussed. Conceptual framework which guided the study and its relevance was also discussed in this chapter. The literature reviewed lacked barriers and enhancers to parent-adolescent discussion on sexual and reproductive health issues and HIV prevention methods in Mount Darwin district and this is what the researcher seeked to cover with this study.

CHAPTER 3 METHODOLOGY

3.1 Introduction

This chapter is going to describe the methodology that was used in the study. The study design, study site, study population, sampling methods, data collection, data analysis, data dissemination and ethical considerations that were used will be highlighted here.

3.2 Study design

A mixed method research approach was used where both cross sectional design was used for quantitative approach and phenomenology design for qualitative approach were employed in the study. However, more weight of the study was put on qualitative study. Qualitative design was used because it provided much more detailed information about adolescents' thoughts and behaviours on sexual and reproductive health issues. The design also provided a complete picture of events that happened and why they happened during parent-adolescent discussions (Morse, 2015).

3.3 Study site

The study was conducted in two high schools in Mount Darwin namely Mount Darwin high school and Chironga high school. Mount Darwin high school is categorized by the ministry of primary and secondary education as secondary school level. The school is located in Mount Darwin town in Mashonaland central province about 160 km north east of Harare. It has a current enrolment of 950 students. The students come from all corners of Mount Darwin district. The school has classes from form one to upper sixth. Form

one to form four has four classes per each form, three lower sixth classes and three upper sixth classes.

Chironga high school is also categorized by the ministry of primary and secondary education as a secondary school level. It is located in the rural areas of Mount Darwin district about 210 km northeast of Harare in Mashonaland central province of Zimbabwe. The school has a current enrolment of 875 students. The students come from all corners of Mount Darwin district. It also has classes for form one to upper sixth. Form one to form four have four classes per each form, three lower sixth classes and three upper sixth classes.

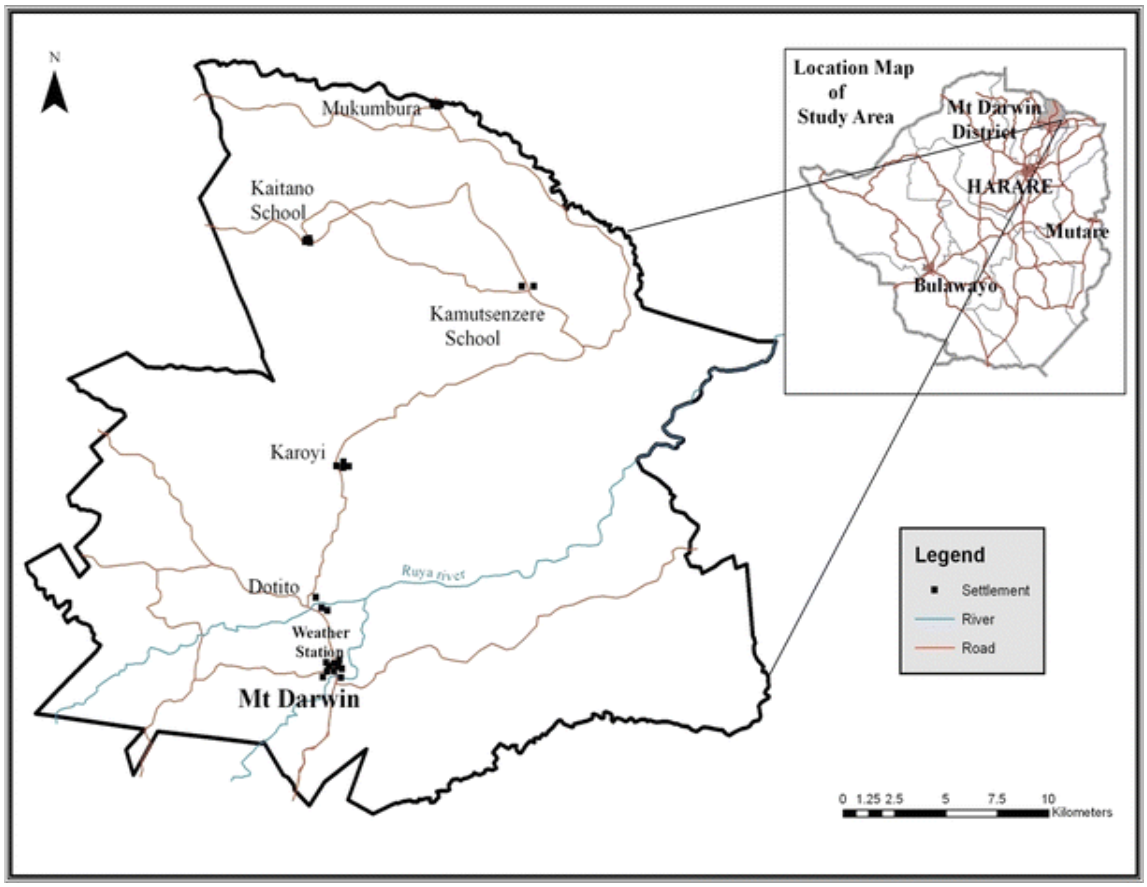

Figure 2: Mount Darwin district map

3.4 Study population

The study included adolescent students aged 15-19 years and their respective parents from the two selected high schools.

3.4.1 Inclusion criteria

The inclusion criteria for adolescents was being a girl or boy aged 15-19 years and attending either Mount Darwin high school or Chironga high school whilst the inclusion criteria for parents was being a parent/guardian for an adolescent aged between 15 and 19 years attending either Mount Darwin high school or Chironga high school and had been selected to participate in the study.

3.4.2 Exclusion criteria

The exclusion criteria for adolescents was being aged less than 15 years or above 19 years and attending any other school which is not either Mount Darwin high school or Chironga high school. The exclusion criteria for parents was being a parent/guardian of either an adolescent aged less than 15 years or an adolescent aged between 15 and 19 years that had not been selected in the study.

3.5 Sample size

The researcher used the policy of the archives of sexual behaviours in coming up with the sample size. The policy adheres to the recommendation of 25 to 30 participants as the minimum sample size required to reach saturation and redundancy in in-depth interviews (Charmaz, 2006). The researcher used this sample size until data saturation was reached. The sample size of 210 participants (120 adolescents and 100 parents) was

enough to maximize the possibility that enough data had been collected to clarify relationships between conceptual categories and identify variation in processes (Morse, 1995). A total of 100 parents were recruited in the study instead of the targeted 120 because 10 of the parents were not available for the interviews on the days of data collection due to pressure of work.

3.6 Sampling procedure

The researcher purposively selected Mount Darwin high school because it is situated in the urban setup of Mount Darwin town and had high enrolment number of student so there were high chances of getting a well-represented sample size. Chironga high school was also sampled using purposive sampling because purposive sampling allowed the researcher to rely on his own discretion, judgement and knowledge when choosing the schools to participate in the study. Purposive sampling also helped the researcher to filter out unpleasant characters of schools such as geographical location and enrolment. Chironga high school is found in the rural setup of Mount Darwin district and had a high enrolment of students which increased the chances of getting a well-represented sample size. Geographically, it was easily accessible making it easier for the researcher to collect data within the short time frame available.

Adolescent participants were selected using stratified random sampling to ensure equal representation by sex among adolescents. The researcher selected adolescents aged 15-19 years in the selected schools in the ratio of 1 girl:1 boy. A lotto method was used where adolescents in each sex stratum were asked to pick a paper from a hat written yes or no. Those who picked a yes were enrolled. Parents to the above selected adolescent

students in each school were then enrolled in the study (Saunders et al., 2018). These same participants, both parent and adolescents, went on to take part in FGDs. A simple random sampling method was used to select those who participated in FGDs. A lotto method was used where participants were asked to pick a paper from a hat written yes or no. Those who picked a yes were enrolled.

3.7 Data collection instruments

Quantitative data was collected using interviewer administered questionnaires. To address issues of reliability and validity, questionnaires were structured taking particular attention to wording of the questions. Clear language was used to construct questions and the use of jargon was avoided. The questionnaire was divided into sections which were arranged in a logical order to ensure logical flowing of questions during the interview. The questionnaire started with simple questions like age of participants and ended by asking more sensitive issues like sexuality issues. To ensure validity and reliability, questions were kept short and specific to SRH issues and one question was asked at a time. No leading and double barreled questions were asked.

Qualitative data was collected using interview guides during focus group discussions (FGDs). Interview guides were used to standardize the discussions and keep the interviewer on track during data collection. To ensure reliability and validity, clear language that the participants could comprehend was used. Jargons were not used during FGDs. The interview guide was constructed using open ended questions to enable the researcher to gather as much information as possible during the FGDs.

3.8 Pretesting of instruments

To ensure validity and reliability of the study results, pretesting of tools was done at Chimumvuri high school in Mount Darwin district. This school was chosen because it had the same set up as the actual study sites. Corrections such as clarity of questions in questionnaires was done prior to the actual data collection procedure. The researcher checked if questions provided insights to the phenomenon the researcher was trying to cover in the study. Where questions were not clear, the researcher reconstructed the wording of the questions, question sequence, appropriateness and meaning of sections in the questionnaires. Responses from the pre-test were excluded from the study, rather they were used for adjusting the research tools (Noble & Smith, 2015).

3.9 Data collection procedure

Data collection was through interviews and focus group discussions (FGDs) using interviewer administered questionnaires and interview guides respectively (Morse, 2015). For quantitative data, interviews were used to collect data. Each participant was interviewed using an interviewer administered questionnaire. Both parents and adolescents were engaged in these interviews. The questionnaire was administered by a registered general nurse who was trained to collect data prior to the data collection sessions. The interviews were conducted in a classroom and each interview lasted for approximately 15 minutes.

After the interviews, qualitative data was then collected using FGDs. Participants were randomly selected from the same participants who participated in intervews for quantitative data. FGDs were led by a registered general nurse (RGN) who was trained

on data collection prior to the data collection sessions. Parents and adolescents were engaged in FGDs but were in separate groups. Adolescents formed their own groups whilst parents formed their own groups. A total of 4 FGDs comprising of 12 adolescent students in each group were conducted in both schools. These FGDs were held in free classrooms at the selected schools and each focus group discussion lasted for approximately 90 minutes. To consider gender balance in adolescent FGDs, a ratio of 1:1 (male: female) was used.

For parents FGDs, a total of 4 FGDs were held for both schools where each group comprised of 12 participants. A registered general nurse led the discussions and the discussions were held in classrooms at selected schools. Each discussion session lasted for approximately 90 minutes.

During the FGDs the researcher asked open ended questions to converse with participants and collect elicit data on parent-adolescent discussion on sexual and reproductive health issues. The discussion offered the researcher an opportunity to prompt the participants and obtain in-depth information which involved perceptions and experiences on parent-adolescent discussion on sexual and reproductive health issues. The discussions also offered the researcher a platform to observe non verbal communication which was pertinent to questions asked (Morse, 2015).

During focus group discussions, a group of adolescents and parents discussed barriers and enhancers of parent-adolescent discussion on sexual reproductive health issues and HIV prevention methods in-depth whilst being facilitated by the registered general nurse. The FGDs technique was based upon the assumption that the group processes

activated during the FGD helped to identify and clarify shared knowledge among groups and community which would be otherwise difficult to obtain with a series of interviews. During the discussions, the FGDs allowed the researcher to solicit both the participants' shared narative as well as their differences in terms of experiences on parent-adolescent discussion on sexual reproductive health issues and HIV prevention methods during such open discussion rounds.

3.10 Analysis and organization of data

Quantitative data was organized using tables and bar graphs. Quantitative data was analysed using advanced statistics from SPSS version 22 using descriptive statictics and bivariate analysis. Bivariate analysis was done to determine relationships between variables. Group differences were determined using chi-squared difference tests.

Qualitative data was organised according to answers for the open ended questions in the interview guide schedule. During FGDs, the researcher wrote notes on what was said by participants. The researcher then developed a coding system which was based on the data collected. The data was grouped according to major themes under the study and their association was identified. Qualitative data was then analysed thematically. The data was presented in the form of narrative notes (Polit & Beck, 2016).

3.11 Ethical considerations

The study was conducted in accordance with three basic ethical principles namely respect for persons, beneficence and justice (Polit & Beck, 2016). Permission and authority was sought from the provincial education director (PED) Mashonaland central province, district medical officer (DMO) Mount Darwin district. Ethical clearance was

sought from AUREC. All participants completed informed consent forms before participation. Participants who were below the age of 18 completed assent forms before participation.

Confidentiality was maintained throughout the research process and after. Confidentiality was maintained by respecting secrets of the participants which were confided to the researcher during interview sessions. Consent and assent was sought to write notes on what was said by the participants during FGDs. Their information and secrets was kept in confidence. The researcher did not share or disclose the information to anyone except to the study team. In cases where disclosure was needed, the researcher seeked consent and assent from the participants to do so (Saunders et al., 2018).

As a way of ensuring confidentiality, interviews were held in a private classroom with the researcher and the participant only where discussions were not overheard by others. Data collected was anonymized by use of number codes on the questionnaires. There were no personal identifiers on all data collection tools. Another way of ensuring confidentiality was that, completed questionnaires were not be left where they can be seen or where other people had easy aceess to them. Soft copies of data collection tools were kept in encrypted files. Rather, the researcher kept all the data collection tools in a lockable cabinet to minimize access by other people for a minimum of five years and thereafter will be destroyed by fire. They were kept for a period of atleast five years after the study to ensure availability of these documents when there is need to this information in the unfortunate case of an unanticipated problem or a complaint (Saunders et al., 2018).

3.12 Summary

This chapter presented the study methodology, outlining the design, the study setting, study population, sampling and sampling procedure, data collection and analysis, plan for dissemination of data together with ethical considerations observed in this study.

CHAPTER 4 DATA PRESENTATION, ANALYSIS AND INTERPRETATION

4.1 Introduction

This chapter is going to look at data presentation, analysis and interpretation. The broad objective of the study was to identify barriers and enhancers to parent-adolescent discussion on sexual reproductive health issues and HIV prevention methods in Mount Darwin. Data was collected between the 24th of January 2022 and the 31st of March 2022. The approximate response rate was 91.7%

4.2 Demographic characteristics

One hundred and twenty adolescents participated in the study where 60 (50%) were girls and 60 (50%) were boys. One hundred parents/guardians also participated in the study where the majority 62 (62%) were females and 38 (38%) were males.

Table 1 below summarizes the demographic characteristics of the respondents that participated in the study.

Table 1: Demographic characteristics: (n = 220)

Demographic characteristics	**Number of respondents (Frequency)**		**Total**
Age in years	**Parent**	**Adolescent**	
15 – 17	0	89	89
18 – 19	0	31	31
40 – 44	30	0	30
45 – 49	60	0	60
50 – 54	10	0	10
Total	**100**	**120**	**220**

Gender	Parent	Adolescent	Total
Female	62	60	134
Male	38	60	106
Total	**100**	**120**	**220**

The mean age for adolescent participants was 17 whilst the median age was 16 (S.D 0.118, 95% C.I), and the mean age for parents was 46 whilst the median age was 46 (S.D 0.345, 95% C.I). Table 2 below shows the mean and median ages for the participants.

Table 2: Mean and median age for participants (n = 220)

	Respondent Status			Statistic	Std. Error
Age	**Parent**	Mean		45.890	0.345
		95% Confidence Interval for Mean	Lower Bound	45.210	
			Upper Bound	46.570	
		5% Trimmed Mean		45.810	
		Median		46	
		Variance		11.897	
		Std. Deviation		3.449	
		Minimum		40	
		Maximum		54	
		Range		14	
		Interquartile Range		5	
		Skewness		0.044	0.241
		Kurtosis		-0.418	0.478
	Adolescent	Mean		16.590	0.118
		95% Confidence Interval for Mean	Lower Bound	16.360	
			Upper Bound	16.830	
		5% Trimmed Mean		16.550	
		Median		16	
		Variance		1.672	
		Std. Deviation		1.293	
		Minimum		15	
		Maximum		19	
		Range		4	
		Interquartile Range		3	
		Skewness		0.375	0.221
		Kurtosis		-0.942	0.438

4.3 Exposure to sexual and reproductive health discussions

The majority of adolescent 65 (54.2%) of the adolescents were never exposed to sexual and reproductive health discussions by their parents whilst 55 (45.8%) of the adolescents were exposed to the discussions by the parents (p-value = 0.038) and this was statistically significant. Among adolescents, girls had significantly higher odds of engaging into SRH discussions with their parents than boys (Odds ration [OR] = 1.2; 95% CI: 0.7 – 2.1; p = 0.046). Adolescents aged 15-17 had significantly higher odds of engaging into SRH discussions than other age groups (OR = 2.4; 95% CI: 0.5 – 11.8; p = 0.029). Among parents, females had significantly higher odds of engaging into discussions on SRH related issues with their children compared to males (OR = 1.3; 95% CI: 0.7 – 2.1; p = 0.038). Parents aged 45-49 had significantly higher odds of discussing SRH related issues with their children (OR = 4.9; 95% CI: 1.0 – 25.0; p = 0.05).

Table 3 below summarizes the bivariate analysis for exposure of participants to parent-adolescent discussions on SRH related issues.

Table 3: Exposure of participants to parent-adolescent discussions on SRH issues (n = 220)

		Exposure to sexual discussion									
		No		Yes		Total				95% Confidence Interval	
		Count	Column N (%)	Count	Column N (%)	Count	Column N (%)	p-value	OR	Lower	Upper
Respondent Status	Parent	60	48	40	42.1	100	45.5	0.038	1.269	0.741	2.173
	Adolescent	65	52	55	45.8	120	54.5	Ref			
Sex	Female	72	57.6	50	52.6	122	55.5	0.046	1.223	0.715	2.091
	Male	53	42.4	45	47.4	98	44.5	Ref			
Age Group	15 - 17	56	44.8	33	34.7	89	40.5	0.029	2.357	0.472	11.770
	18-19	9	7.2	22	23.2	31	14.1	0.010	9.778	1.729	55.304
	40 - 44	25	20	5	5.3	30	13.6	0.810	0.8	0.129	4.952
	45 - 49	27	21.6	33	34.7	60	27.3	0.050	4.889	0.957	24.973
	50-54	8	6.4	2	2.1	10	4.5	Ref			
How often do you receive sex education	Weekly	0	0	37	38.9	37	38.5	0.426	1.017	0.984	1.052
	Monthly	1	100	58	61.1	59	61.5	Ref			

4.4 Frequency of discussions

The majority of adolescents 34 (57%) received sexual education monthly and the majority of parents (54.2%) discussed SRH related issued with their children on monthly basis. Adolescents aged 15-17 years discussed more (35.6%) on monthly basis (p-value = 0.289) whilst parents aged 45-49 discussed more on monthly basis (p-value = 0.289) and was statistically insignificant.

Table 4 below summarizes the analysis for the frequency of discussions.

Table 4: Frequency of discussions (n = 220)

		How often do you receive sex education				
		Weekly		**Monthly**		
		Count	**Column N (%)**	**Count**	**Column N (%)**	**p-value**
Exposure to sexual discussion	No	0	0	1	1.7	0.426
	Yes	37	100	58	98.3	
	Total	37	100	59	100	
Respondent Status	Parent	15	40.5	25	54.2	0.859
	Adolescent	22	59.5	34	60.7	
Sex	Female	18	48.6	33	55.9	0.486
	Male	19	51.4	26	44.1	
Age Group	15 – 17	12	32.4	21	35.6	0.289
	18-19	10	27	13	22	
	40 – 44	4	10.8	1	1.7	
	45 – 49	10	27	23	39	
	50-54	1	2.7	1	1.7	

4.5 Frequently discussed topics

From the findings, the most frequently discussed topic was HIV/AIDS (65%) followed by STIs (64%), followed by puberty (62%), followed by advantages of young people avoiding sexual behavior (58%) and sex before marriage (52%). Other topics discussed included human reproduction (48%), issues of becoming sexual active (49%), social issues relating to sex (40%), safe sex (41). The least discussed topics included where to get condoms (20%), contraception (22%) and importance of using protection (30%).

Figure 3 below summarizes the topics that participants had discussed.

Figure 3: Frequently discussed topics

4.6 Location of sexual and reproductive health discussions

The majority (76.3%) of respondents (parents and adolescents) stated that they conduct their sexual and reproductive health (SRH) discussions from home whilst the remaining 23.7% stated that they conduct them at school. Participants had significantly higher odds of conducting SRH related discussions at home as compared to conducting them at school (OR = 1.5; 95% CI: 0.6 – 3.8; p = 0.042). All respondents (100%) stated that they were comfortable with their locations of conducting the discussions.

Table 5 below shows the bivariate analysis of the location of SRH discussions.

Table 5: Location of SRH discussion (n = 220)

		Sex Female		Male		Total				95% Confidence Interval	
		Count	Column (N) %	Count	Column (N) %	Count	Column (N) %	p-value	OR	Lower	Upper
Where do you hold most of your sex education discussions? Home	No	14	26.9	9	20	23	23.7	0.042	1.474	0.568	3.824
	Yes	38	73.1	36	80	74	76.3				
Where do you hold most of your sex education discussion? School	No	38	73.1	36	80	74	76.3	0.424	0.679	0.262	1.761
	Yes	14	26.9	9	20	23	23.7				
Where do you hold most of your sex education discussions? Church	No	52	100	45	100	97	100				
	Yes	0	0	0	0	0	0				
Are you comfortable with these places?	No	0	0	0	0	0	0				
	Yes	52	100	45	100	97	100				

4.7 Methods of discussions

Parents and adolescents used dialogue, question and answer, use of learning aides and arguments as methods of discussion (p-value = 0.065) and this was statistically insignificant.

The table below summarizes the methods of discussion used by participants.

Table 6: Methods of discussion. (n = 220)

		Sex						
		Female		**Male**		**Total**		
		Count	**Column N (%)**	**Count**	**Column N (%)**	**Count**	**Column N (%)**	**p-value**
Method of discussion used - Dialogue/discussion	No	29	55.8	28	62.2	57	58.8	0.52
	Yes	23	44.2	17	37.8	40	54.2	
Method of discussion used - Question and answer	No	34	65.4	23	51.1	57	58.8	0.154
	Yes	18	34.6	22	48.9	40	38	
Method of discussion used - Use of learning aides for demonstration	0	44	84.6	34	75.6	78	80.4	0.262
	1	8	15.4	11	24.4	19	17	
Method of discussion used – Arguments	0	50	98	40	88.9	90	93.8	0.065
	1	1	2	5	11.1	6	6.3	

The most commonly used methods of discussion for adolescents are dialogue/discussion (54%) (p-value = 0.52), question and answer (38%) (p-value = 0.154), use of learning aides for demonstration (17%) and arguments (4.2%) whilst for parents are

dialogue/discussion (46%), question and answer (31%), use of learning aides for demonstration (10%) and arguments (4%).

Figure 4 below shows the methods of discussion that parents and adolescents use to discuss sexual and reproductive health related issues.

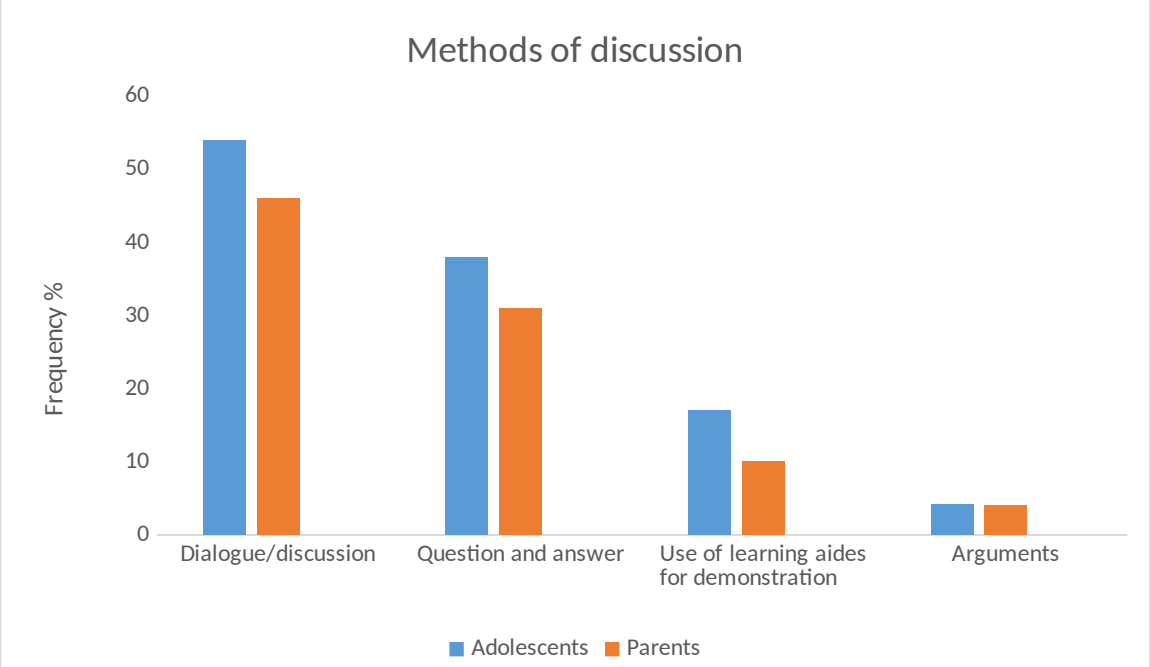

Figure 4: Methods of discussion

4.8 Barriers and enhancers to parent-adolescents' discussions

There were 48 adolescents and 48 parents/guardians from 2 schools available for interviews. There were a total of 2 adolescent focus group discussions at each school, each group comprising of 12 adolescents. This was the same for the FGDs for parents.

The following are the themes for parent-adolescent discussions on sexual and reproductive issues grouped as findings from adolescents and parents/guardians.

4.8.1 Findings from adolescents

4.8.1.1 Theme 1: Parent-adolescent discussion on sexual and reproductive issues is important but missed

Adolescents expressed that parent-adolescent discussion on SRH related issues was not a common practice among them and their parents. They also showed that they considered these discussions important and were willing to engage their parents in such discussions. The group reached a consensus with what was said by an adolescent boy aged 17 from one of the focus group discussions who explained, "*I would have loved to discuss this area with my father, I only see this type of conversations in movies on the television and I want to have firsthand feeling of the discussion. I wish it can also happen in my family too."*

There was also group consensus with another 18-year-old girl in the FGD who explained that, "*It will be a good thing to do to have such a discussion with my parents but however, it's not possible in our setting because of certain reasons like culture. We only see it on television happening in western countries*."

A 15-year-old girl in the group discussion reiterated that, "*I feel it's an important discussion to have because it brings me close to my parents and be open to them but unfortunately this is not happening back at home*." The whole group agreed on this statement.

4.8.1.2 Theme 2: Few parent-adolescent discussion practices

Adolescents felt that parent-adolescent discussions on SRH related issues were not a common practice and there were a lot of parental factors that hindered the initiation of these discussions between them and their parents.

A consensus was reached by the group to was commented by a nineteen-year-old boy during the discussion. The boy commented that, "*My father usually avoids such discussion. Whenever such pictures or videos appear on television he switches channels so that I don't see it or he sends me to sleep before its time. He does that because if I see I end up asking too many questions*."

Another participant who was a 15-year-old girl in the FGD explained that, "*After my mother told me about the changes that happens to my body at puberty and why it is important to know about methods of contraception our discussion ended there*." The whole group agreed on this statement.

An eighteen-year-old girl during the FGDs commented that, "*After I read about methods of contraception in the book I then asked my mother about it so that she can clarify it to me but she just said what you have read is true. I had so many questions but I was afraid to ask her and I was shy as well*." Another 16-year-old girl explained that, *"I tried once to ask my mother about menstruation but she said I should ask my aunt such issues."* A nineteen-year-old boy in the fourth focus group discussion said, "*Since I 'am part of this community my experience is not different from that of my colleagues, I do not engage in*

discussions about sexual issues with my parents." A group consensus was reached on the above statements.

4.8.1.3 Theme 3: Puberty time to initiate discussions

The results showed that parents delay the discussions till their adolescent children are at puberty. Adolescents believed that parents waited until they reach puberty for them to initiate discussions on SRH related issues. During a focused group discussion, a consensus was reached on what was said by an eighteen-year old girl. The girl explained that, *"It is not the same to face a problem after you are informed and before you are informed. I think this information would benefit many girls if it was to be shared before puberty.*" Another seventeen-year-old girl commented that, *"Our parents do not give us proper information on how to do sex safely before puberty, instead they threaten you and show their power during that time.*" The whole group agreed on this. A fifteen-year-old boy in another FGD explain that, *"When my father noticed some changes that comes with puberty on m, that is when he started to explain what changes I should expect through the process of adolescence*." A group consensus was reached on this statement.

4.8.1.4 Theme 4: Cultural construct as the main problem

Parents still consider having discussions with their adolescent children a taboo. Results from FGDs showed that parents believe that it is not culturally acceptable for them to engage into discussions with their adolescent children. A group consensus was reached in a FGD where a sixteen-year-old boy in the discussion commented that, "*This is still not common in our Zimbabwean culture. In our culture it is considered a taboo and so embarrassing for a parent to discuss sexual and reproductive issues with their children.*"

Another eighteen-year-old girl from another group discussion reiterated that, "*The major thing that cause our parents to shun down these discussions is culture. That is how they were brought up, they were brought up in a closed society where parents would not discuss such issues with adolescents*." The whole group agreed on this statement.

4.8.1.5 Theme 5: Gender and age influence on discussions

Gender is a barrier to initiate discussion between parent and their adolescents. Adolescents feel comfortable to discuss sexual and reproductive issues with the parent of the same sex. A sixteen-year-old girl in one of the discussions commented that*, "I feel so embarrassed and ashamed to discuss about my menstrual periods with my father. I would rather not have such a discussion at all."* A group consensus was reached on this statement. Another group consensus was reached on what was explained by a seventeen-year old girl in the group. She explained that, "*It is true that most of the times girls talk to their mothers about their sexual issues whilst boys prefer to talk to their father than mothers except if their father is arrogant.*"

Another seventeen-year-old boy who was in one of the groups said that, "*The generational gap that exists between us and our parents makes it difficult for us to have such discussions with them. I feel its proper to discuss with our friends, whether it's about girlfriend or any other body changes than to discuss it with our parents. This is because we are on the same age and generation with our friends and it is easier to understand each other*." Another fifteen-year-old girl echoed the same sentiments that, "*It is easier to discuss with my siblings because we are in the same age group and its easier to discuss sensitive issues with them*." A group consensus was reached on these statements.

4.8.1.6 Theme 6: Parents deny their responsibility

Parents believe it is the responsibility of their children's aunts, uncles, teachers and pastors to discuss sexual issues with their adolescent children. A fifteen-year-old girl who was in one of the groups said that, "*I asked my mother about the changes that happened to me at puberty but she brushed me aside saying I should wait for my aunt to tell me as that what was culturally right*." Another eighteen-year-old boy commented that, "*The reason why they don't tell us about these issues is because they think we will get the necessary information from church by youth leaders and from school by science teachers.*" The whole group agreed on these statements. In another FGD, a consensus was reached on what was explained by a sixteen-year-old boy who explained that, "*My father said I should discuss those issues with my uncle.*"

4.8.1.7 Theme 7: Parents' fear

Parents fear that discussing those issues with their adolescents is like authorizing them to indulge in sexual activities at a tender age. A nineteen-year-old girl commented during a FGD that, "*Our parents feel that giving us information on sexual and reproductive issues may push us to the wrong direction*." There was group consensus on this statement. Another sixteen-year-old girl in the focus group discussion explained that, "*My mother said if she tells me about sex she fears that I will try to experiment on what she would have told me.*" The group also agreed on this explanation.

4.8.1.8 Theme 8: Adolescents have better knowledge than their parents

Parents feel embarrassed to talk about sexual issue with their adolescents because they feel these children have better knowledge than they have because they have better exposure due to the internet and media. A fifteen-year-old girl in the group discussion said that, "*Our parents are not well informed as far as these sexuality, family planning and reproductive health issues are concerned so they are not comfortable to discuss with us because they feel we know better than them.*" Another eighteen-year-old boy commented that, "*When I asked my father about the use of condoms he said I had better knowledge than him since he ended up at primary level and I was doing form four.*" A group consensus was reached on both contributions.

4.8.1.9 Theme 9: Religion is a barrier

Parents believe it is not morally right to encourage their adolescents to use contraception before they are married as this sounds like promoting adultery. A group consensus was reached to what was said by a seventeen-year-old girl where she elaborated that, "*My mother is a deacon at our church and she said to me I can't teach you on how to use contraception. This will encourage you to indulge in sex before marriage and this is against the will of God.*"

4.8.1.10 Theme 10: Parents are busy

Parents have no time to sit down with their children as they are always busy with their works. During the FGD, a group consensus was reached on what was said by an eighteen-year-old boy where he complained saying that, "*Maybe it is because my parents usually stay out of home for different activities. They are very busy people*."

Another fifteen-year-old girl elaborated, "In the first place my mother had no time to sit down and talk to me." A group consensus was also reached on this contribution.

4.9 Findings from parents

The findings were almost similar to the findings from adolescents and were put under same themes

4.9.1 Theme 1: Parent-adolescent discussions on sexual and reproductive health issues is important but missed

Parents feel that the discussions are important though they do not conduct them. A group consensus was reached to what was said by a forty five-year old mother where she explained, "*I think it is a good thing to give time and discuss sexual and reproductive issues with our children*." Another forty-nine-year-old father commented, *"I never engaged in such a discussion with my boy because he dedicates much of his time reading school work. He has no time to be exposed to sexual things."* A group consensus was reached on this contribution.

4.9.2 Theme 2: Few parent-adolescent discussion practices

The majority of the parents do not engage into sexual and reproductive issues discussions with their adolescence due to factors like cultural influences. The group agreed on what was said by a fifty-year-old mother where she explained during the focus group discussion that, "*There is no such discussion in my house. In most cases I do not consider it as a big issue so I never thought of discussing around that issue.*" A fifty-two-year-old father in another focus group discussion also explained, *"How can I have*

such a talk with my children? No parent in his right senses can talk about sex with his/her children." The group reached consensus on the contribution.

4.9.3 Theme 3: Puberty time to initiate discussions

Parents delay discussions until it is puberty time. They feel it is not important to discuss about SRH related issues with their children before puberty because they will be too young to understand such issues. A forty-six-year-old father commented, "*I wait and only talk when I see something different on my boy. I tell him to take care*." Another fifty-two-year-old mother explained, "*I started this discussion when she reached puberty and we were talking about the changes around adolescence*." The group reached consensus on both contributions.

4.9.4 Theme 4: Culture as the problem

Parents were brought up in a cultural setting were parents were not to discuss sexual issues with their children. It was a taboo so they wish to carry on with the same legacy. A group consensus was reached where a fifty-one-year-old father in the FGD said, "*It is how I was brought up, and it is the influence of our culture. Long back during our days, our parents used not to do this*." Another group consensus was reached in the FGD where a fifty-four-year-old mother explained, "*That is how I was brought up myself, my mother never discussed such issues with me and similarly I don't have the courage to discuss with my own child.*"

4.9.5 Theme 5: Parents are busy

Parents are hardly home because of work and when they get home they will be too tired to have a discussion with their children. A group consensus was reached where a forty-year-old father said, *"We are struggling with so many things and we spend the whole day standing at work trying to make ends meet. We don't give them enough time to discuss.*" A forty-two-year-old mother also commented, "*When I go home after work I will be so busy with other things like cooking and planning my work for the following day. I have no time for those discussions.*" A group consensus was also reached on this contribution.

4.9.6 Theme 6: Parents deny responsibility

Parents believe that adolescence have different sources where they can get information on sexual and reproductive issues like from the school, media, uncle and aunt. A group consensus was reached where a forty-five-year-old mother explained, "*I cannot teach her things that she is being taught at school*." A forty-seven-year-old father said, "*Children of nowadays are very privileged. They have so many sources they can get this information on sexual and reproductive health like the television, school and magazines.in that case it is not my responsibility to do so*." A group consensus was also reached in another FGD where a fifty-four- year-old mother said, "*During our adolescent days that information was given to us by our aunts, so I guess that duty should be done by their uncles and aunts*."

4.9.7 Theme 7: Adolescents have better knowledge

Parents feel that their children have better knowledge on sexual and reproductive health than they have. A consensus was reached in a FGD where a fifty-four-year-old mother

explained that, "*Some of us did not get to secondary school where these children are right now so obviously they know better than we do. We have nothing to tell them.*" A fifty-year-old father in a FGD said, "*These kids are now exposed to a lot of information they get from their cellphones and television so they have better knowledge than ours. We cannot have a discussion with them.*"

4.9.8 Theme 8: Fear from parents of early sexual engagement

Parents fear that exposing their adolescents into sexual and reproductive discussion will push them in having early sex. A forty-one-year-old mother in the FGD commented, "*I fear that talking about such issues with my girl is like giving her the green light to have sex with boys*." Another forty-four-year-old father in the FGD said, "*I am afraid that if I discuss this type of issues with my child I may push him in the wrong direction of life*." Group consensus was reached on both contributions.

4.9.9 Theme 9: Gender and age influence on discussion

Parents are not comfortable to discuss sexual and reproductive issues with children of opposite sex. They also feel that there is a big generational gap between them and their children. A group consensus was reached duty the FGD where a fifty-three-year-old father said, "*I think my son should discuss sexual issues with his peers because they belong to the same generation and understand each other better.*" Another group consensus was reached where a fifty-year-old-mother said, "*I do not feel comfortable to discuss sexual issues with my son, it's weird. It was going to be better if it was a girl*."

4.9.10 Theme 10: Religion as a barrier

Parents also raised religion as a barrier that limit them from talking about sexual issues with their adolescents. They feel that encouraging their adolescent children to engage in safe sex before they are married is against the holy bible which encourages Christians not to indulge into adultery. A group consensus was reached in the FGD where a forty-nine-year-old mother said, "*In churches we encourage our children to get married whilst they are virgins through abstinence but here I am talking about using condoms at home. Don't you see that I will be contradicting myself*?" Another forty-four-year-old father in the FGD explained, "*The bible says no to adultery, so teaching my children about methods of contraception is like I am promoting adultery there by going against the bible*." A group consensus was reached on this contribution.

4.10 Enhancers of discussions

4.10.1 Findings from adolescents

4.10.1.1 Theme 1: Perceived benefits

Adolescents believed that engaging in sexual and reproductive health discussions will protect them from harmful sexual health related issues like contracting HIV, STIs, having unwanted pregnancies and avoid early marriages since they will be knowledgeable. They believe that once they don't get into early marriages that will allow them to finish their school and be successful in life. A group consensus was reached during a FGD where a fifteen-year-old girl explained, "*I engage in discussions on sexual and reproductive related issues with my mother so that I will be knowledgeable on how to evade unwanted pregnancies and contracting HIV*." Another seventeen-year old girl in the group discussion said, "*I am motivated to have these*

discussions with my parent because once I am knowledgeable I avoid early marriages and finish my school and become successful later in life." The whole group agreed on this contribution.

4.10.1.2 Theme 2: Fear for stigma

Fear of the stigma that comes with contracting HIV also drives adolescence to engage into discussions with their parents. A group consensus was reached where an eighteen-year-old boy in one of the discussions commented, *"When you get HIV people in the community will always talk about you and others will even laugh at you. That fear makes me want to seek information from my father so that I have safe sex.*" Another consensus was reached where a sixteen-year-old girl in the group discussion explained, "*There is stigmatization which comes with an unwanted pregnancy, early marriage and contracting HIV. I am afraid of that stigma and that usually pushes me to discuss these issues with my mother*."

4.10.2 Findings from parents

4.10.2.1 Theme 1: Perceived benefits

Benefits that comes with a successful child pushes parents to engage into discussions on sexual and reproductive issues. These benefits include paying of a bride price for the girl child, weddings and keep the family reputation. A consensus was reached during a FGD where a forty-two-year-old mother said, "*If I teach my daughter on sexual and reproductive issues she will make me proud on her wedding day and I will get benefits from payments of her bride price*." Another forty-six-year-old mother in the group commented, "*If my daughter does not bring unwanted pregnancies at home it will*

maintain the reputation of our family.' There was a group consensus on this contribution.

4.10.2.2 Theme 2: Fear for stigma

Parents said if their adolescents fall pregnant with a lot of unwanted pregnancies and get into early marriages it will bring shame to the family. The need to guard family reputation pushes them into having discussions with their children. A consensus was reached during a FGD where a fifty-four-year-old father explained, *"I don't teach my children the importance of contraception they will bring shame to my family if they fall pregnant*." Another forty-five-year-old mother in one of the FGD said, "*I have to discuss these issues with my girls because if they bring unwanted pregnancies home the shame and blame will be on me*." A group consensus was reached on this contribution.

4.11 Summary

The chapter presented the results of the study taking particular attention on the demographic characteristics of the study participants, exposure of participants to parent-adolescent discussion on SRH related issues, frequency of discussions, frequently discussed topics, barriers and enhancers of parent-adolescent discussion on SRH related issues.

CHAPTER 5 SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter is going to look at the discussion of the results, conclusions drawn from the discussion, implications, recommendations and suggestions for further research. The chapter also shows the integration between qualitative and quantitative results.

5.2 Discussion

The study found out that only 45.8% of the adolescents have had parent-adolescent discussion on sexual and reproductive health issues. This shows that sexual and reproductive health related topics continues to be a sociocultural taboo between adolescents and their parents. The study provided the evidence that there is a limited parent-adolescent discussion practice but however, most of the adolescents are willing to engage their parents in the SRH related discussions but unfortunately there are parental

factors that hinders the initiation of such discussions. The findings were similar to the findings by Yibrehu and Mbwele (2020) on their study in Ethiopia where they reported that there was a limited practice on parent-adolescent communication in Ethiopia.

The study also found out that the mostly discussed topics were HIV/AIDS (65%), and puberty (62%). This is because HIV/AIDS is considered a catastrophic disease that interferes with the family economic resources and family lineage by killing adolescents before they reach adulthood. Puberty is considered the first indicator for parents to initiate SRH discussions with their adolescents. The least discussed topics were areas to get condoms (20%), methods of contraception (22%) and the importance of using protection (30%). This was probably because parents did not want to focus more on those areas because they seem like they are promoting promiscuity. This concurs with the findings of Nigussie et al. (2020) in their study in Ethiopia where the most discussed topics were STIs, mainly HIV/AIDS.

The study also revealed that discussions were 1.5 times more likely to be done at home between mothers and girls than at school (OR = 1.5; 95% CI: 0.6 – 3.8; p = 0.042). The study showed that girls were 1.2 times more likely to engage into SRH related discussions with their parents (OR = 1.2; 95% CI: 0.7 – 2.1; p = 0.046) and mothers were 1.3 times more likely to engage into SRH related discussions with their children (OR = 1.3; 95% CI: 0.7 – 2.1; p = 0.038) as compared to fathers. This is because the majority of mothers are housewives who had enough time to talk with their adolescents at home and girls are considered to be more vulnerable than boys. This is in line with the results of a study by Nigussie et al. (2020) where it was found that most of the discussions were done at home between mothers and their girl adolescents.

It was found in this study that the most commonly used method of discussion was a dialogue/discussion (54%). This was because most parents in Mount Darwin have low levels of education. The majority reached primary level as their highest level of education and were not able to use other methods of discussion available such as the use of learning aides for demonstration. This concurs with the results for a study by Njenga (2015) in Kenya where he found out that the majority of participants (28.5%) in that study used dialogue/discussion as a method of discussion.

The study found out that culture is one of the major barriers why parents do not discuss sexual and reproductive health (SRH) related issues with their adolescents. This is probably because the study was done in a setup where there is a strong rural background where the population has strong cultural roots. Generally, the Zimbabwean culture considers parent-adolescent discussion on SRH issues a taboo. The findings were similar to those by Yibrewu and Mbwele (2020) where they reported that culture is one of the barriers to parent-adolescent discussion on SRH related issues. The results also echoed the same sentiments as to what was found by Shilton et al. (2019) where they found out that knowledge, Ethiopian laws, culture and co-operation affected the utilization of WHO's preventing early pregnancy guidelines.

The study also found out parents' denial of their responsibility as another barrier. This is probably because of lack of knowledge on the area of discussion and because of the strong cultural beliefs which prohibits parents to discuss sexual issues with their adolescents. Parents end up shifting the responsibilities to aunts and uncles according to tradition and teachers. These finding were in line with the findings by Yibrewu and

Mbwele (2020) where they said one of the factors that hinders parent-adolescent communication is parent's denial of their responsibility.

Another barrier is parent's occupation where parents are too busy to discuss sexual and reproductive issues with their adolescents due to tight schedules at work. They usually come back home tired or they hardly avail themselves for discussions. This was the same with what Svodziwa et al. (2016) found in their study in Zimbabwe where occupation of parents was found to be a barrier in parent-adolescent discussion on sexual and reproductive health issues. They found out that parents will be too busy to have a discussion with their children because of tight schedules at work.

The study also found out that parent's low knowledge and awareness is also a barrier in parent-adolescent discussion on SRH issues. This is because the majority of parents in Mount Darwin attended school to primary level and as a result they have little or no knowledge. These parents with little or no knowledge have no content to tell their children and do not know how to use different mediums of teaching besides dialogue. This is in line with what Seif & Kohi (2014) found out where they said that the problem of limited knowledge among parents prevents them from discussing with their adolescents. This is because the parents do not know how to discuss such issues because they are not informed.

It was found out in the study that religion also act as a barrier to parent-adolescent discussion on sexual and reproductive health issues and HIV preventive methods. This is because the greater number of Christians prohibit their followers from committing adultery. They encourage abstinence so for a parent to encourage his/her to use methods of contraception like condoms is like encouraging adultery which is contrary to their

belief. This is consistent to what Svodziwa et al. (2016) found in their study in Zimbabwe it was found that religious beliefs are a stumbling block to discussions between parents and adolescents on issues of sexuality and reproductive health. Another study by Bushaija et al. (2013) showed the same results were they were quoted saying Christians cannot advice their adolescent children to use condoms, it's immoral. Extreme religious practices have prevented parents to discuss with their children on the best ways to reduce sexual and reproductive health risks.

The study also found that gender and age differences can act as a barrier to discussions on SRH related issues. This is because mothers and fathers of the adolescents discuss more with the child of the same sex. This is attributed to the fact that both parents feel shy to discuss openly with a child of opposite sex. Age or generational gap is another stumbling block. This is because of the different experiences that exist between different generations. The results of this study concur with the findings by Kamangu et al. (2017) where parents revealed in their study that they find it difficult to discuss with children of a different sex because it's a shame for them or even the child. Another study by Bushaija et al. (2013) showed the same results where they said mothers communicate more with girls rather than boys and fathers rarely discuss with boys than girls.

Another factor found by this study as a barrier is fear of early adolescent sexual engagement by parents. Parents fear that if adolescents are exposed to issues of sexuality they would want to experiment with the information given to them so they would rather not engage into discussions with then to avoid this. This is in concurrence with the findings of a study by Yibrewu and Mbwele (2020) where they found out that fear of early adolescent sexual engagement by parents was a barrier. However, these findings

were contrary to the findings by Njenga (2015) where they found that fear was not a barrier to parent-adolescent communication on SRH related issues. This might be due to the fact that the studies were done in different setups and in a population with different cultures.

The study found out perceived benefits as an enhancer to parent-adolescent discussion on SRH related issues. The benefits that comes with parent-adolescent open discussion on SRH issues and HIV prevention methods includes economic benefits like daughter's bride price and the desire to maintain family reputation. These results are consistent with the findings by Usonwu et al. (2021) where it was found out that adolescents believed that receiving education from their parents can help protect them from harmful sexual health related issues and hence the need for open discussion with parents on issues of sexuality. The findings were however contrary to the findings by Nigussie et al. (2020) where it perceived benefits were found to have little effects on parent-adolescent discussion on SRH related issues. This may be due to the fact that Zimbabwe and Ethiopia share different cultures.

Another enhancer found by this study was fear of stigma. Parents and adolescents fear stigma and shame that comes with contracting HIV/AIDS, unwanted pregnancies and abortion hence the need to engage into parent-adolescent discussions because they believe they have a protective effect. These results concur with the results of a study by Usonwu et al. (2021) where they said parents initiated discussions from a place of fear. In their study, parents expressed that they were driven to initiate sexual health discussions because they were apprehensive of children bringing the family name to disrepute in the community. The results were however contrary to the findings by

Yibrehu & Mbwele (2020) where they found fear to be a barrier more that an enhancer. This is probably because of the difference in study settings and different population with different characteristics.

5.3 Conclusions

The study concludes that parent-adolescent discussion on sexual and reproductive health and HIV preventive methods is not a common practice among the people of Mount Darwin district. Adolescents in Mount Darwin have shown interest in the discussion of sexual and reproductive health issues and HIV preventive methods but there are more parental factors that limit the discussion. The study also concludes that the least discussed topics among parents and adolescents are methods of contraception, where to get condoms and the importance of using protection during sexual intercourse. Most parents and adolescents prefer to use dialogue as a method of discussion.

The study concludes that culture, religion, occupation, parental low knowledge, gender and age differences, parental fear of adolescent early sexual engagement and parental responsibility denial are barriers of parent-adolescent discussion on sexual and reproductive health issues and HIV prevention methods in Mount Darwin district. The study also concludes that perceived benefits and fear of stigma are enhancers of parent-adolescent discussion on sexual and reproductive health issues and HIV prevention methods in Mount Darwin district.

5.4 Implications

The study showed that the parent-adolescent discussion on sexual and reproductive health issues and HIV prevention methods is not a common practice and there are a lot

of barriers to these discussions in Mount Darwin. This leads to inconsistent condom use, sexual intercourse with multiple partners among adolescents and increases chances of having unplanned pregnancies, early marriages, unsafe abortions and transmission of HIV/AIDS and other sexually transmitted infections.

With these many barriers in place, this thwarts the ministry of health and child care's efforts to implement interventions that reduce unwanted pregnancies, child marriages, STIs and HIV/AIDS transmission and unsafe abortions among adolescents. This has an impact of having high HIV prevalence among adolescents, severe medical complications, preterm labor's, low birth weight infants and increased maternal and new born mortality rates.

5.5 Recommendations

The ministry of health and child care through the clinical directors for adolescent sexual and reproductive health and the permanent secretary for the ministry in collaboration with the ministry of primary and secondary education through the district schools inspector (DSI) and the permanent secretary in the ministry to come up with a special curriculum on parent-adolescent discussion on sexual and reproductive health issues and HIV prevention methods to be incorporated and promoted in schools by teachers targeting adolescents to initiate open discussions with their parents.

The ministry of health and child care through the hospital outreach programs and community health workers to do community based awareness campaigns targeting

parent's knowledge and attitudes providing them with the much needed information to boost their knowledge and clearing cultural misconceptions on parent-adolescent discussion on SRH related issues and HIV prevention methods.

Adolescent sexual reproductive health clinical directorate at Mashonaland central provincial medical director's (PMD) office and at district level to conduct seminars and workshops aiming at providing parents with information and skills to enable them to overcome the discussion barriers about sexuality.

The finance ministry though it's permanent secretary to avail enough funding for training programs on parent-adolescent discussions involving the wider community in appreciating the significance of parent-adolescent discussions on sexuality issues.

5.6 Suggestions for further research

The study had a limited scope in that it only focused on barriers and enhancers on parent-adolescent discussion on sexual and reproductive health issues and HIV prevention methods in Mount Darwin district which is more of a rural set up. There is need to carry out a further research for a comparative study to establish barriers and enhancers of parent-adolescent discussion on sexual and reproductive health issues and HIV prevention methods in an urban setup so that the picture of the Zimbabwean situation on this issue is complete.

The study only focused on barriers and enhancers of parent-adolescent discussion on sexual and reproductive health issues and HIV prevention methods in Mount Darwin

district, there is also need to carry out a study to establish the influences of parent-adolescent discussion on sexual and reproductive behavior among adolescents.

5.7 Dissemination of findings

After the study results were out, the researcher went back to the health facilities and the high schools where participants in the study came from and reported the results of the study through oral briefings and meetings with the health care workers in the areas where the schools are built and with the school authorities. The researcher also attended the district health team meetings and reported the results in the meetings. The researcher also prepared a formal study report which was sent to the Mashonaland central provincial medical director (PMD) and the provincial education director (PED) reporting the findings of the study. Above all, the researcher planned to publish the findings of the study in the journal of health.

5.8 Delimitations

The study only focused on identifying barriers and enhancers to parent-adolescent discussion on sexual reproductive health issues and HIV prevention methods in Mount Darwin. It was confined to two high schools in Mount Darwin only where participants were sampled from with their respective parents. However adequate participants were sampled for the purpose of this study so that the results were more generalizable. The researcher did not look at more than stated number of schools because of time and cost constraints. If a large number of schools in the district was sampled, a larger sample size of participants was required which in turn would need more time and resources.

5.9 Limitations of the study

One of the major limitations to the study was bias. Participants tend to provide bias information. They told the researcher what they perceived was what the researcher wanted to hear. Lack of financial rewards for participants also presented as another limitation for the study. Financial rewards motivate participants to take part in research studies. Lack of financial reward may cause low response rate for the study. Time and financial resources constraints were also limitations for the study. The research covered a smaller study site as well as the sample size which made the results less generalizable.

List of References

Brook, D., Morojele, N., Zhang, C. & Brook, J. (2006). South African adolescents: pathways to risky sexual behaviour. *AIDS Education and Prevention, 18*(3), 259-272.

Bushaija, E., Sunday, F., Asingizwe, D., Olayo, R., & Abong'o, B. (2013). Factors that hinder parents from the communicating of sexual matters with adolescents in Rwanda. *Rwanda Journal of Health Sciences, 2*(2), 13-19.

Butts, S., Kayukwa, A., Langlie, J., Rodriguez, J., Alcaide, L., Chitalu, N., … Jones, L. (2018). HIV knowledge and risk among Zambian adolescent and younger adolescent girls: challenges and solutions. *Sexual Education, 18*(1), 1-13.

Charmaz, K. (2006). *Constructing a grounded theory: A practical guide through qualitative analysis (7th ed.).* London: Sage publications.

Eisenberg, M., Sieving, R., Bearinger, L., Seain, C. & Resnick, M. (2006). "Parents' communication with adolescents about sexual behaviour: A missed opportunity for prevention?" *Journal of Youth and Adolescence, 35*(6), 893-902.

Gizaw, A., & Jara, D. (2014). Risky sexual practice and associated factors among high school adolescent in Addis Ababa, Ethiopia. *Journal of Family Medicine & Medical Science Research, 3*(4), 141-152

Government of Zimbabwe. (2019). *Global AIDS response progress report 2019*. Harare.

Hutchinson, M.K., Jemmott, B., Jemmott, S., Braverman, P., & Fong, T. (2003). The role of mother-daughter sexual risk communication in reducing sexual risk behaviors among urban adolescent females: A prospective study. *Journal of Adolescent Health, 33*(2), 98-107.

Jaccard, J., Dodge, T., & Dittus, P. (2002). Parent-adolescent communication about sex and birth control: A conceptual framework. *Journal of New Directions for Child and Adolescent Development, 97*(1), 9-42.

Kajula, J., Darling, N., Kaaya, F., & De Vries, H. (2016). Parenting practices and styles associated with adolescent sexual health in Dar es salaam, Tanzania. *Journal of AIDS Care, 18*(1), 15-25.

Kamangu, A., John, A., & Nyakoki, S. (2017). Barriers to parent-child communication on sexual and reproductive health issues in east Africa: A review of qualitative research in four countries. *Journal of African Studies and Development, 9*(4), 45-50.

Kassahun, A., Gelagay, A., & Muche, A. (2019). Factors associated with early sexual initiation among preparatory and high school youths in Woldia town, northeast Ethiopia: a cross-sectional study. *Journal of BMC Public Health, 19*, 378.

Krugu, K., Mevissen, F., Prinsen, A., Ruiter, C., & Muleya, M. (2016). Who's that girl? A qualitative analysis of adolescent girls' views on factors associated with teenage pregnancies in Bolgatanga, Ghana. *Journal of Reproductive Health, 13*(39), 317-328.

Mahapatra, B., & Saggurti, N. (2014). Exposure to pornographic videos and its effect on HIV-related sexual risk behaviours among male migrant workers in southern India. *Plos One, 9*(11), 300-311.

Mavhunga, C. (2021). *Zimbabwe reports major rise in teen pregnancies during pandemic*. COVID 19 pandemic. Voice of Africa.

Mazengia, F., & Worku, A. (2009). Age at sexual initiation and factors associated with it among youths in north East Ethiopia. *Ethiopian Journal of Health Development, 23*, 154-162.

Mekie, M., Addisu, D., Melkie, A., & Taklual, W. (2020). Parent-adolescent communication on sexual and reproductive health issues and its associated factors in Ethiopia: A systematic review and meta-analysis. *Italian Journal of Pediatrics, 46*, 162.

Morse, J.M. (1995). The significance of saturation. *Qualitative Health Research, 5*(2), 147-149.

Morse, J.M. (2015). Critical analysis of strategies for determining rigor in qualitative inquiry. *Qualitative Health Research, 25*(9), 1212-1222.

Muhwezi, W., Katahoire, R., Banura, C., Mugooda, H., Kwesiga, D., Bastien, S., & Klepp, I. (2015). Perceptions and experiences of adolescents, parents and school administrators regarding adolescent–parent communication on sexual and reproductive health issues in urban and rural Uganda. *Reproductive Health, 12*, 110.

Mullis, M., Kastrinos, A., Wollney, E., Taylor, G., & Bylund, C. (2021). International barriers to parent-child communication about sexual and reproductive health topics: a qualitative systematic review. *Sex Education, 21*(4), 387-403.

Nigussie, A., Demissie, G., & Abedaw, G. (2020). Parent-adolescent communication on sexual and reproductive health issues and associated factors among preparatory and secondary school students of Dabat town, northeast of Ethiopia. *Journal of Environmental and Public Health, 2020*(375), 1-7.

Njenga, G. (2015). *The influence of parent-adolescent communication on sexual and reproductive behaviour of adolescents: Case study of Kibera Slums*. Nairobi. Kenya.

Noble, H., & Smith, J. (2015). Issues of validity and reliability in qualitative research. *Evidence-Based Nursing. 18*(2). 34-35.

Nolin, M. (2002). Gender differences in parent-child communication about sexuality: an exploratory study. *Journal of Adolescent Research, 7*(1), 102-108.

Polit, D., & Beck, C. (2016). *Nursing research: Generating and assessing evidence for nursing practice (10th ed.)*. Philadelphia, PA: Wolters Kluwer Health.

Resnick, D., Bearman, P., Blum, R., Bauman, K., & Harris, K. (1997). Protecting adolescents from harm: findings from the national longitudinal study on adolescent health. *Jama, 278*(10), 822-834.

Saunders, B., Sim, J., Kingstone, T., Baker, S., Waterfield, J., Bartlam, B., … Jinxs, C. (2018). Saturation in qualitative research: Exploring its conceptualization and operationalization. *Quality and Quantity. 52*(4), 1893-1907.

Seif, S.A., & Kohi, T.W. (2014). Caretaker-adolescent communication on sexuality and reproductive health: My perceptions matter; A qualitative study on adolescents' perspectives in Unguja-Zanzibar. *Health, 6*(21), 2904-2917.

Shiferaw, K., Getahun, F., & Asres, G. (2014). Assessment of adolescents' communication on sexual and reproductive health matters with parents and associated factors among secondary and preparatory schools' students in Debremarkos town, north West Ethiopia. *Reproductive Health, 11*(1), 2.

Shilton, S., Chandra-Mouli, V., Paul, S., & Denno, D. (2019). Facilitators and barriers in the utilization of World Health Organization's preventing early pregnancy guidelines in formulating laws, policies and strategies: What do stakeholders in Ethiopia say? *International Journal of Adolescent Medicine and Health, 33*(5), 1105-1110.

Svodziwa, M., Kurete, F., & Ndlovu, L. (2016). Parental knowledge, attitudes and perceptions towards adolescent sexual reproductive health in Bulawayo, Zimbabwe. *International Journal of Humanities Social Sciences and Education, 3*(4), 62-71.

Joint United Nations Programme on HIV/AIDS. (2019). *Women and HIV - a spotlight on adolescent girls and young women*. Geneva.

United Nations Childrens' Fund. (2018). *Investing in a safe, healthy and productive transition from childhood to adulthood is critical*. Adolescents overview.

United Nations Development Programme. (2016). *The state of adolescent sexual and reproductive health*.

United Nations Population Fund. (2016). *Facing the challenges of adolescent pregnancy in Zimbabwe*.

United Nations Population Fund. (2020). *Facing the challenges of adolescent pregnancy in Zimbabwe.*

Usonwu, J., Ahmed, R., & Curtis-Tyler, K. (2021). Parent-adolescent communication on adolescent sexual and reproductive health in Sub Saharan Africa: a qualitative review and thematic synthesis. *Reproductive Health, 18*(1), 202.

Wado, Y.D., Sully, A., & Mumah, N. (2019). Pregnancy and early motherhood among adolescents in five east African countries: a multi-level analysis of risk and protective factors. *BMC Pregnancy and Childbirth, 19*(1), 59.

Weinman, M.L., Small, E., Buzi, R.S., & Smith, P. (2008). Risk factors, parental communication, self and peers' beliefs as predictors of condom use among female adolescents attending family planning clinics. *Child and Adolescent Social Work Journal, 25*, 157-170.

Whitaker, D. J., & Miller, K. S. (2000). Parent-adolescent discussions about sex and condoms: Impact on peer influences of sexual risk behaviour. *Journal of Adolescent Research, 15*(2), 251-273.

World Health Organization. (2016). *The global strategy for women's, children's and adolescents' health (2016-2030)*. WHO. Geneva. Switzerland.

World Health Organization. (2018). *Recognizing adolescence. Adolescence: a period needing special attention*.

Yibrehu, M., & Mbwele, B. (2020). Parent-adolescent communication on sexual and reproductive health: the qualitative evidences from parents and students of Addis Ababa, Ethiopia. *Reproductive Health, 17*(1), 78.

APPENDICES

APPENDIX 1: Informed Consent

STUDY TITLE

Barriers and enhancers to parent-adolescent discussion on sexual reproductive health issues and HIV prevention methods in Mount Darwin.

Introduction

You are asked to participate in the study because parent-adolescent discussion on sexual and reproductive health issues is one of the interventions that encourage adolescents to delay sexual debuts or avoid unprotected sexual intercourse. This results in reduced cases of unwanted adolescent pregnancies, early child marriages and unsafe abortions. This study desires to identify barriers and enhancers to parent-adolescent discussions on sexual reproductive health issues and HIV prevention methods in Mt Darwin district.

Choice to withdraw or leave the study

Participation is purely voluntary. You can choose to or not to participate in this study. If you choose not to participate or leave the study during the interview process, you may do so freely without any consequences against you.

Harm and/or risks and/or discomforts

We anticipate no harm/risk/discomfort to occur during the discussion. Privacy and confidentiality will be observed and protected. Interview will take place in private. If risks do appear, interviews will be foregone and rescheduled.

Benefits

No costs are expected during the interviews, there is no remuneration for participating in this study. You are free to ask for further clarifications as need be. Your participation will help the MOHCC to improve the adolescent sexual and reproductive health (ASRH) implementation in the country and formulate policies that improve ASRH services countrywide.

Privacy of records

All information provided will be kept confidential by all means. You will only be identified by the questionnaire code and personal information from the interview will not be released without your written permission.

In case of any questions, please contact

Victor Mombo

Cell phone number: 0774412852.

Email: mombov@africau.edu

Declaration of volunteer

I Mr./Miss/Mrs.……. do hereby give consent to Victor Mombo to include me in the proposed study entitled**: Barriers and enhancers to parent-adolescent discussion on sexual reproductive health issues and HIV prevention methods in Mount Darwin**. I have read the information sheet. I understand the aim of the study and what will be required of me if I take part in the study. The risks and benefits if any have been explained to me. Any questions I have concerning the study have been adequately answered. I understand that I can withdraw from the study at any time if I so wish without any consequences. I realize I will be interviewed once. I consent voluntarily to participate in this study.

Respondent's Name …….

Signature or left thumb print

…….. Date / ……

Name of person taking consent

……..

Signature / ……. Date / ……..

Name of Investigator ……

Signature …….. Date ……..

APPENDIX 2: Assent Form for 15-17 year-old

This form provides you important information about the research study you are being asked to participate in. Please read it carefully and understand. When you are finished you should know what the research study is about, what you will be asked to do and what are likely risks and benefits. If you agree to participate, you will be asked to signs this form. A copy of the form should be given to you.

STUDY TITLE

Barriers and enhancers to parent-adolescent discussion on sexual reproductive health issues and HIV prevention methods in Mount Darwin.

Introduction

You are asked to participate in the study because parent-adolescent discussion on sexual and reproductive health issues is one of the interventions that encourage adolescents to delay sexual debuts or avoid unprotected sexual intercourse. This results in reduced cases of unwanted adolescent pregnancies, early child marriages and unsafe abortions. This study desires to identify barriers and enhancers to parent-adolescent discussions on sexual reproductive health issues and HIV prevention methods in Mount Darwin district.

Choice to withdraw or leave the study

Participation is purely voluntary. You can choose to or not to participate in this study. If you choose not to participate or leave the study during the interview process, you may do so freely without any consequences against you.

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Declaration of volunteer

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Respondent's Name …….

Signature or left thumb print

…… Date / ……

Name of person taking consent

……..

Signature / ……. Date / ……..

Name of Investigator ……

Signature …….. Date ……..

APPENDIX 3: Interview Guide for Focus Group Discussion

1. What are some of the factors that cause adolescents to engage in early sexual activities and early marriages?
2. Explain the extent to which parent-adolescent discussion influences adolescent's sexual and reproductive behavior in Mt Darwin.
3. In your own opinion, does parent-adolescent discussion influence adolescents to indulge in sex at an early age?
4. Does parent- adolescent discussion contribute to healthy sexual behavior of adolescents in Mt Darwin?
5. Does sexual content in parent-adolescent discussion promote riskier sexual behavior among adolescents in Mt Darwin?
6. Are different methodologies of parent-adolescent discussion on sexual and reproductive behavior associated with different types of sexual behavior among adolescents in Mt Darwin?
7. In your own opinion, how does parent-adolescent discussion influence sexual and reproductive behavior among adolescents living in Mt Darwin?
8. What are some of the challenges/barriers of parent- adolescent discussion on issues of sexual reproductive health and HIV prevention methods?
9. What are some of the enhancers of parent-adolescent discussion on issues of sexual reproductive health and HIV prevention methods?
10. Explain to what extent exposure to parent-adolescent discussion influences the following sexual behaviors among adolescents living in Mt Darwin:

i. Abstinence

ii. Masturbation

iii. Petting behaviors

iv. Oral sex

v. Anal sex

Thank you very much for your participation

APPENDIX 4: Questionnaire for Adolescents' Interviews

Part A: Personal information

Age: [ ]

Gender: Male [ ] Female: [ ]

Part B: How parents discuss sexual and reproductive information with their adolescents.

1. Have you ever been exposed to any sex education by your parents?

   Yes [ ] No [ ]

   If yes, in what level?

   Primary level [ ] Secondary level [ ]

2. How often do you receive sex education from your parents?

   Daily [ ] Weekly [ ]

   Monthly [ ] Never [ ]

3. Which of the following topics have you learnt in sex education? Tick where appropriate (X)

	(X)
Human reproduction	
Issues in becoming sexual active	
The advantages of young people avoiding sexual behavior	
HIV/AIDS	
STIs	

Importance of using protection	
Where to get condoms	
Social issues relating to sex	
Contraception	
Safe sex	
Sex before marriage or peer pressure	
Puberty	
Coercion and assault	
Others ……	

4. Where do you hold most of your sex education sessions from?

   Home [ ] School [ ]

   Church [ ] Other ……

   Are you comfortable with these places?

   Yes [ ] No [ ]

5. Tick one method among the ones listed below that your parents use to discuss sex related issues with you:

   a) Dialogue/ Discussion [ ]

   b) Lecture method Dictation (Talk and make notes) [ ]

   c) Use of learning aids for demonstration [ ]

   d) Question/Answer methods [ ]

   e) Debates [ ]

Part C: The influence of parent-adolescent discussion on sexual and reproductive behavior

6. Are you sexually active?

   Yes [ ] No [ ]

   If yes, at what age was your first was your first indulge in a sexual relationship?

   17 or younger [ ] 18 or older [ ]

7. Do conversations between you and your parent influence your sexual behavior?

   Yes [ ] No [ ]

8. Complete the following items about the conversations between you and your parent on sexual matters. Use the following scale to indicate your feelings about that specific conversation. There is no right or wrong answer. The scale ranges from 1 (strongly disagree) to 5 (strongly agree).

	1	2	3	4	5
Our conversation was very beneficial					
It was a useless conversation					
It was a helpful conversation					
My parent(s) was an unhelpful communicator(s)					
The conversation was very unrewarding					

APPENDIX 5: Questionnaire for Parents' Interviews

Part A: Personal information

Age: [ ]

Gender: Male [ ] Female: [ ]

Part B: How parents discuss sexual and reproductive information with their adolescents.

1. Have you ever exposed your children to any sex education?

   Yes [ ] No [ ]

   If yes, in what level?

   Primary level [ ] Secondary level [ ]

2. How often do you give sex education to your children?

   Daily [ ] Weekly [ ]

   Monthly [ ] Never [ ]

3. Which of the following topics have you taught your children in sex education? Tick where appropriate (X)

	(X)
Human reproduction	
Issues in becoming sexual active	
The advantages of young people avoiding sexual behavior	
HIV/AIDS	
STIs	

Importance of using protection	
Where to get condoms	
Social issues relating to sex	
Contraception	
Safe sex	
Sex before marriage or peer pressure	
Puberty	
Coercion and assault	
Others ……	

4. Where do you hold most of your sex education sessions from?

   Home [ ] School [ ]

   Church [ ] Other ……

   Are you comfortable with these places?

   Yes [ ] No [ ]

5. Tick one method among the ones listed below that you use to discuss sex related issues with your children:

   f) Dialogue/ Discussion [ ]

   g) Lecture method Dictation (Talk and make notes) [ ]

   h) Use of learning aids for demonstration [ ]

   i) Question/Answer methods [ ]

   j) Debates [ ]

Part C: The influence of parent-adolescent discussion on sexual and reproductive behavior

6. Are your children sexually active?

   Yes [ ] No [ ]

   If yes, at what age do you think your adolescent child indulge in a sexual relationship?

   17 or younger [ ] 18 or older [ ]

7. Do conversations between you and your adolescent children influence their sexual behavior?

   Yes [ ] No [ ]

8. Complete the following items about the conversations between you and your child on sexual matters. Use the following scale to indicate your feelings about that specific conversation. There is no right or wrong answer. The scale ranges from 1 (strongly disagree) to 5 (strongly agree).

	1	2	3	4	5
Our conversation was very beneficial					
It was a useless conversation					
It was a helpful conversation					
My child(ren) was an unhelpful communicator(s)					
The conversation was very unrewarding					

APPENDIX 6: Permission to Conduct Study from PED

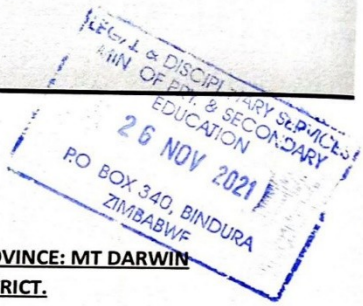
F: C/440/1MC

All communications should be addressed to
"The Provincial Education Director
Mashonaland Central Province"
Telephone:0271- 6948/6996/7134/6994
Fax:0271-6997

ZIMBABWE

Ministry of Primary and Secondary Education
Mashonaland Central Province
P.O Box 340
Bindura
Zimbabwe

26 November 2021



Victor Mombo
Karanda Mission Hospital
Mt Darwin

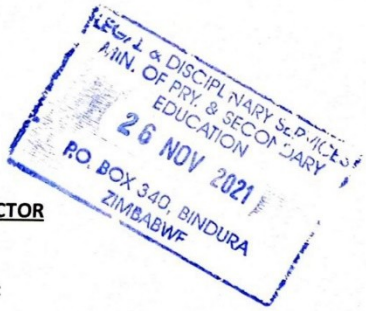
RE: <u>PERMISSION TO CARRY OUT RESEARCH IN MASHOLAND CENTRAL PROVINCE: MT DARWIN DISTRICT: MT DARWIN HIGH,CHIRONGA HIGH SCHOOL: MT DARWIN DISTRICT.</u>

Reference is hereby made to the Dean, College of Health, Agriculture and Natural Science minute Africa University dated 28 May 2021 requesting for permission for you to carry out a research in Mashonaland Central Province, Mt Darwin District on the research title:

"IDENTIFYING BARRIERS AND ENHANCERS TO PARENT –ADOLESCENT DISCUSSION ON SEXUAL REPRODUCTIVE HEALTH ISSUES AND HIV PREVENTION METHODS IN MT DARWIN."

I am pleased to inform you that the Provincial Education Director has granted you permission to carry out your research Mt Darwin District. You should, however, liaise with the D.S.I. Mt Darwin District before you start.

Finally, you are advised to submit a copy of your findings to the Ministry of Primary and Secondary Education.



.....

MADZVIMBO N.
Human Resources Officer
<u>FOR PROVINCIAL EDUCATION DIRECTOR</u>
Mashonaland Central Province
/cc
Permission to carry out research doc